Maternal and Child Health Services
Title V Block Grant

State Narrative for Arkansas

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

All assurances and certifications are kept on file in the Center for Health Advancement, located in the Arkansas Department of Health in Little Rock.

/2012/ The Arkansas Department of Health currently has all assurances and certifications on file with HHS. Most recently updated on 7/13/2010. //2012//

/2013/ The Arkansas Department of Health currently has all assurances and certifications on file with HHS. Most recently updated on 7/13/2010. //2013//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Among the avenues for public input into the activities supported by the Title V Maternal and Child Health Block Grant is a survey of the family planning patients who utilize the Arkansas Department of Healths clinics. This survey asks family planning patients about their level of satisfaction with the services they have received, the wait times they experienced, how accessible the services were, as well as their impression of the staff who served them. This information is used in evaluating the individual clinics as well as identifying problems that are systemic to the program. In turn this helps identify problem areas that are considered when planning and development of new initiatives are undertaken by the MCH program. Other avenues for public input include, but are not limited to the parent/advisory group for CSHCN and the survey CSHCN conducts with parents and families.

As prescribed by the Federal Government as part of the application process, the first of two Public Hearings for the 2011 Title V Maternal and Child Health Block Grant application took place on July 1, 2010. The hearing took place at the Arkansas Department of Health Auditorium in Little Rock, Arkansas starting at 2:00 pm. A notice was placed in the Arkansas Democrat Gazette-Northwest, the Arkansas Democrat Gazette-Little Rock and Hola Arkansas in both English and Spanish, for seven consecutive days, one month previous to the hearing. Notices were also placed on the Arkansas Department of Health website and the Arkansas State Calendar of Public Meetings website during the 30 day period preceding the public hearing. Copies of the draft application and report were made available for review at the hearing. Eleven people attended the hearing, and there were no questions or comments.

The second MCH Block Grant Public Hearing took place on August 3rd, 2010, at which time copies of this document were shared and open for discussion. The hearing took place at the

Arkansas Department of Health Auditorium in Little Rock, Arkansas starting at 2:00 pm. A notice was placed in the Arkansas Democrat Gazette-Northwest, the Arkansas Democrat Gazette-Little Rock and Hola Arkansas in both English and Spanish, for seven consecutive days, one month previous to the hearing. Notices were also placed on the Arkansas Department of Health website and the Arkansas State Calendar of Public Meetings website during the 30 day period preceding the public hearing. Although no public comments were made during the public hearing, we will continue to welcome comments from the parent/advisory group for CSHCN, as well as other groups with input regarding the served population.

/2012/ As noted above opportunities for public input into the activities supported by the Title V Maternal and Child Health Block Grant include a survey of the family planning patients who utilize the Arkansas Department of Healths clinics. This survey asks family planning patients about their level of satisfaction with the services they have received, the wait times they experienced, how accessible the services were, as well as their impression of the staff who served them. This information is used in evaluating the individual clinics as well as identifying problems that are systemic to the program. In turn this helps identify problem areas that are considered when planning and development of new initiatives are undertaken by the MCH program. Other avenues for public input include, but are not limited to the parent/advisory group for CSHCN and the survey CSHCN conducts with parents and families.

As prescribed by the Federal Government as part of the application process, the first of two Public Hearings for the 2011 Title V Maternal and Child Health Block Grant application took place on July 1, 2011. The hearing took place at the Freeway Medical Building in Little Rock, Arkansas starting at 2:00 pm. A notice was placed in the Arkansas Democrat Gazette-Northwest, the Arkansas Democrat Gazette-Little Rock and Hola Arkansas in both English and Spanish, for seven consecutive days, one month previous to the hearing. Notices were also placed on the Arkansas Department of Health website and the Arkansas State Calendar of Public Meetings website during the 30 day period preceding the public hearing. Copies of the draft application and report were made available for review at the hearing. Thirteen people attended the hearing, and two comments were made. The first comment was making note of increase opportunity for family participation and input into the CSHCN activities supported by the grant. The second comment was by the Senior vice president of Arkansas Children's Hospital noting the increase in partnerships between the MCH grantee and other stakeholders in the state on child health issues. That this has a positive impact on focusing the state's resources on improving the health of its children.

The second Public Hearing took place on September 2, 2011. Once again, the hearing was advertised and notices placed on the Arkansas Department of Health website. Comment was made by Mr. Bryan Cozart who works for the Arkansas Disability Coalition. He is the director of the Family-2-Family Health Information Center project at ADC. He stated that since the creation of this porgram in 2009, the Title V Children with Special Healthcare Needs program has been an invaluable partner. With a sub-grant from the Title V Children with Special Healthcare Needs program, they have been able to double the number of families they serve. On a personal note, he related that he was the father of a 10 year old with special healthcare needs and the Title V Children with Special Healthcare Needs program has provided an invaluable service to them. He encourages everyone to support the program that is having such a positive impact on families in Arkansas. //2012//

/2013/ As noted above opportunities for public input into the activities supported by the Title V Maternal and Child Health Block Grant include a survey of the family planning patients who utilize the Arkansas Department of Healths clinics. This survey asks family planning patients about their level of satisfaction with the services they have received, the wait times they experienced, how accessible the services were, as well as their impression of the staff who served them. This information is used in evaluating the individual clinics as well as identifying problems that are systemic to the program. In turn this helps identify problem areas that are considered when planning and development of new

initiatives are undertaken by the MCH program. Other avenues for public input include, but are not limited to the parent/advisory group for CSHCN and the survey CSHCN conducts with parents and families.

As prescribed by the Federal Government as part of the application process, the first of two Public Hearings for the 2013 Title V Maternal and Child Health Block Grant application took place on June 28, 2012. The hearing took place at the Freeway Medical Building in Little Rock, Arkansas starting at 2:00 pm. A notice was placed in the Arkansas Democrat Gazette-Northwest, the Arkansas Democrat Gazette-Little Rock and Hola Arkansas in both English and Spanish, for seven consecutive days, one month previous to the hearing. Notices were also placed on the Arkansas Department of Health website and the Arkansas State Calendar of Public Meetings website during the 30 day period preceding the public hearing. Copies of the draft application and report were made available for review at the hearing. Twelve people attended the hearing, and three comments were made. The first comment was made by the Director of the Arkansas Home Visiting Network. She noted that the MCH Block Grant contibuted to many good things for women and children in our state, but we still had many problems that are not being addressed, such as food security and lack of safe housing. Next, the Parent Consultant made note of the increase in family participation and input into the CSHCN activities supported by the grant. The third comment was by the Senior vice president of Arkansas Children's Hospital noting the increase in partnerships between the MCH grantee and other stakeholders in the state on infant mortality, MIECHV, the Infant and Child Death Review, Coordinated School Health, School Wellness Centers, Health Literacy and Injury Prevention, as well as issues around hunger and Children with Special Health Care Needs.

The second Public Hearing took place on September 7, 2012. Once again, the hearing was advertised and notices placed on the Arkansas Department of Health website. Twelve people were in attendence. Comment was made by Mr. Bryan Cozart who works for the Arkansas Disability Coalition. He is the director of the Family-2-Family Health Information Center project at ADC. He stated that since the creation of this porgram in 2009, the Title V Children with Special Healthcare Needs program has been a strategic partner. They have been extremely supportive, both with time and resources, and also with funding. With a sub-grant from the Title V Children with Special Healthcare Needs program, they have been able to go around the state to directly support families and provide training to both families and professionals. Mr. Josh Heimburg who works with the Arkansas Children's Hospital Research Institute, stated that a grant from the state MCH was enabling them to build infrastrucure for children with special healthcare needs in Arkansas, focusing on youth transition into adult care. Additionally, they have been working with Title V to create a strategic plan for the the entire state. With their help have brought groups of stakeholders into planning meetings that included both families and professionals. Teery Love of the March of Dimes stated that there was mutual support between the MCH leaders and MOD in working on goals related to the maternal and child health of Arkansas. //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

State priorities formed as a result of the last 5-year needs assessment remain the same. These priorities include:

1. Reduce births to older teens

2. Reduce smoking among women of reproductive age

3. Improve childhood trauma care

4. Improve oral health in children and women

5. Reduce obesity and overweight among school-aged children

6. Improve communication between the Title V CSHCN program and the CSHCN population

7. Improve training and program development for the Title V CSHCN workforce

Population-specific needs relevant to most of the above priorities have not changed significantly in the last year. Births to older teens have fallen off dramatically over the past two years in Arkansas (about 20%), but improvements have occurred nationally as well and Arkansas continues to exceed the US rate. Children with major trauma are now being transported to a Level 1 pediatric trauma center in almost every case, a very gratifying improvement, but again Arkansas still has catching up to do in terms of childhood injury mortality compared to the nation as a whole. Indicators for fluoridation, childhood obesity, and smoking among women of childbearing age have not improved; the last of these actually increased last year. Family CSHCN survey responses indicate improvement in CSHCN program staff communication of information that is beneficial to families. 66% of respondents stated that CSHCN staff had shared information with them on other services available within the past 12 months. This is an increase of over 13 percent from last year. An annual anonymous survey of employees regarding training needs, program needs and development and work environment provides a means of communication that has been helpful as program management assesses future changes.

In summary, the above state priorities and associated performance measures will be continued in the coming year.

Capacity to address the state priorities has shown some changes over the last year. Relevant to births to older teens, another satellite family planning clinic has been established, this one at a community college in Northeast Arkansas. Although not a system capacity change per se, long-acting reversible contraceptive methods are being more aggressively promoted to older teenagers; the usage rate of intrauterine devices or systems increased to 4% of all women this age receiving contraception through ADH family planning clinics in 2011. More impressively, the proportion of 18-19 year olds using Depo-Provera as their primary method increased to 31% in CY11 compared to 26% in CY10. Additionally, abstinence-only education as well as PREP grant activities targeting teens in foster care were added last year. The state trauma system has also shown remarkable development in the last year alone (see SPM3). For children specifically, another Level 1 pediatric hospital (LeBonheur Children's in Memphis) has been added that will greatly improve the outlook for severely injured youngsters in East Arkansas. For water

fluoridation efforts, Delta Dental of Arkansas Foundation has pledged at least $2,000,000 to provide water systems affected by Act 197 of 2011 with needed equipment. The Foundation has also pledged to help some smaller systems fluoridate their water, which ultimately will result in about 90% of Arkansans (on public systems) receiving appropriately fluoridated drinking water.

The Arkansas Systems Improvement Project (ARSIP), the D70 Systems Improvement for CSHCN in Arkansas, has recently completed year-1. Perhaps the greatest overall accomplishment has been the strategic relationships between project staff and Arkansas CYSHCN Stakeholders. ARSIP leads a monthly CYSHCN consortium meeting of 15 to 25 persons representing multiple state agencies, community groups, and families. ARSIP staff regularly meets with individual stakeholders one-on-one to introduce the project, identify mutual goals, and invite them to the consortium. In the spring of 2012 the consortium developed a statewide strategic plan for system of care needs for CYSHCN in Arkansas that culminated in a day-long strategic planning meeting that addressed the current Title V Needs Assessment and the Maternal and Child Health Bureau (MCHB) Core Outcomes. Three English and one Spanish statewide family focus groups occurred in June of 2012. The focus groups content will refine the strategic plan, which will be published after a brief public comment period during the summer of 2012.

ARSIP continues to work closely with its subcontractors, including Title V CSHCN; Arkansas Family-2-Family Health Information Center (F2F); and the Arkansas chapter of the American Academy of Pediatrics (ARAAP). All of the subcontractors attend the monthly consortium meetings and the ARSIP staff meet with the subcontractors individually on at least a monthly basis. ARSIP staff have built a particularly close relationship with Title V CSHCN and collaborated on presentations, survey design and collection, and family needs assessments.

The ARSIP has successfully recruited key stakeholders to address the topic of youth health care transitions. ARSIP has formed a transitions work group that meets monthly. Current attendees represent Arkansas Children's Hospital, University of Arkansas for Medical Sciences, and the Title V CSHCN work group. The transition work group has identified a number of transitions tools, developed a logic model for promoting health care transitions, and had a consultation visit from Dr. Carl Cooley of the Got Transitions center. The ARSIP transitions group is also collaborating with a new transitions work group with Title V, families, and representatives from Arkansas Children's Hospital.

The 5-year needs assessment has been posted on the MCH website and plans are to post it on the ADH website as well. The needs assessment has been shared with the ADH special advisor on strategic initiatives for use in the agency's public health accreditation process. It has also been utilized heavily by the recipients of the D70 System of Care Grant for CYSHCN funded through HRSA.

The Family Health Branch continues to continuously collect and assess data relative to the priority areas. Vital statistics data along with family planning service reports (including a new Business Objects report specific to teen clients) are used to monitor the births-to-older-teens priority. Reproductive behavior among this age group is monitored through surveys such as the Youth Risk Behavior Survey and Pregnancy Risk Assessment Monitoring System (PRAMS). The Behavioral Risk Factor Surveillance System (BRFSS) helps track tobacco usage among women of childbearing age along with the Arkansas Tobacco Survey conducted through the Tobacco Prevention and Cessation Program. The Office of Oral Health tracks public water system fluoridation progress very carefully and shares these updates with Family Health staff. Likewise, the Trauma Section has an extensive database and shares a number of indicators of progress in addition to the one mentioned in state priority #3. Results of body mass index measurements of Arkansas school-aged children are disseminated by the Arkansas Center for Health Improvement. The Family Health Branch has rapid access to these figures and also carefully reviews annual evaluations carried out by the UAMS College of Public Health pertaining to Act 1220 of 2003 (an anti-obesity legislative act). The CSHCN-related state priorities are monitored

through annual surveys conducted by the program itself.

An ongoing collaborative effort involving the needs assessment is being conducted with Arkansas Children's Hospital (ACH), which will use the data in the needs assessment and other key health statistics supplied by ADH as part of its hospital needs assessment process. ACH will in turn share some of its data (from surveys, focus groups, key informants, etc.) with ADH that are relevant both to the most recent as well as the next 5-year MCH needs assessment. Additional information from specific communities comes from surveys conducted through the Hometown Health Improvement Initiative. The Title V CSHCN program conducts interim surveys for ongoing update and assessment of needs. An annual survey was sent to the parent/guardian of 690 CYSHCN actively served by the program. In years' past, the return rate was low, so changes were made this year. Recipients of the survey were randomly selected with assistance from Research and Statistics staff within DHS. The survey was developed in collaboration with Dr. Dennis Kuo and ARSIP staff. Incentives were offered to encourage completion and submission of the survey. The process was a success this year. 344 surveys were returned for a 50% response rate. Another ongoing survey activity conducted by the Title V CSHCN program is the Transition survey sent to every YSHCN on the database in the month of their 14th birthday. The responses are shared with staff who then assist the youth and parent/guardian in addressing the issues elicited with the survey. However, the response rate is rather poor so our plan is to revise the survey itself with the assistance of the ARSIP staff and make other changes in the process to encourage better response. The ARSIP grant is currently completing four family focus groups statewide with one of those targeting Hispanic consumers. The topic addressed in the focus groups is the information from the strategic planning session.

III. State Overview

A. Overview

1. State Characteristics

As of 2008, Arkansas's population stood at 2.86 million people spread across 75 counties. Among states, Arkansas has high proportions of rural, low income and minority citizens. A very broad range of health measures in this state rank unfavorably compared to other states. These include many of the data trends captured in the MCH Block Grant performance measures. Arkansas's five health regions are diverse in geography and demography. The Central Region around Little Rock is relatively urban and well supplied with available health services for women and children. However, even in these counties low-income families experience barriers in access to care. All other regions are rural and poor and many are medically undeserved as defined by HRSA programs. Counties along the eastern border of Arkansas, the Mississippi Delta, are especially rural and poor and have high concentrations of minority populations, especially African American. Counties along the western border are mountainous and rural. They have fewer minorities, but are high impact for immigrant Hispanic families from Central and South America. A group of Marshallese families live in the far northwestern counties and experience outbreaks of infectious diseases including STIs, TB and Hansen's Disease. Counties along the southern border of the state are also rural and poor, depending on farming and timber as their predominant source of income.

2. The broader health delivery system

The city of Little Rock, the state's largest, is situated approximately in the middle of the state, and is the site for five large hospitals, the University of Arkansas for Medical Sciences (UAMS - the medical school), the Arkansas Department of Health (ADH), the Arkansas Department of Human Services (DHS), and other state agencies relating to the health of women and children. Cities of moderate size are located in the corners of the state, including Fayetteville and Fort Smith in the northwest, Jonesboro in the northeast, Hot Springs in the midwest, Texarkana in the southwest, El Dorado in the mid south, and Pine Bluff in the Delta Region of the Mississippi River. These cities provide the population base for sizable medical communities and are the locations of Area Health Education Centers (AHECs). Over the state as a whole, the number of physician practices is barely adequate to provide the necessary medical services, but in certain underserved areas, physician and other health provider shortages are common. UAMS, based in Little Rock, provides a centralized point of referral for all medically complicated patients, and also provides medical and health education for the entire state. Except for the communities of West Memphis and perhaps Helena on the eastern border of the state who depend on the city of Memphis in Tennessee, all state communities relate to UAMS and Little Rock hospitals as the major source of highly specialized medical care. The AHECs provide Family Medicine residency training in communities around the state, and have been of great assistance in improving the distribution of primary care physicians to the corners of the state. By far the most numerous specialty in Arkansas, family physicians provide most of the state's medical care. Specialists in obstetrics, pediatrics, internal medicine, surgery and others have practices in the more urban communities. While Arkansas is geographically of modest size compared to some other states, the distances from cities such as Fayetteville and Texarkana to Little Rock require two and one-half to four hours of travel time. For families with few resources, these distances represent significant barriers in access to highly specialized care.

A major advance in both access to care and provider education occurred in 2009 with the opening of UAMS Northwest, a 325,000 square foot facility located in Fayetteville. The site is expected to educate 250-300 students when fully operational, including medical, pharmacy, nursing, and allied health professions. Faculty, medical students, and residents have already begun training at the site. Arkansas Children's Hospital has also established a satellite facility in northwest Arkansas at Lowell, which is staffed by the UAMS Department of Pediatrics.

3. The system of state agencies providing support to the health system for women and children.

Following separation from the Arkansas Department of Human Services in 2007 after a two-year "marriage," the Arkansas Department of Health (ADH) is again an independent, cabinet-level agency. A table of organization for the ADH is attached under III.C., Organizational Structure.

Dr. Paul Halverson is the Director of the ADH, and serves as Secretary to the State Board of Health. Dr. Joseph Thompson serves as the chief medical adviser to the Governor (referred to as the state's "Surgeon General"). Both are cabinet positions and are active in the deliberations of the Arkansas Board of Health, though the Surgeon General does not have a vote, and the Director may not serve as chair. ADH structure includes the Executive Staff (providing overall leadership), and five Centers, including Local Public Health, Health Advancement, Health Protection, Health Practice, and the State Laboratory. MCH services are coordinated through the Family Health Branch in the Center for Health Advancement.

Since 2007, both the structure and the focus of the "new" ADH have become well established. As State Health Officer, Dr. Paul Halverson conducted a strategic planning process in 2008. Guided by a nationally experienced facilitator, the ADH Executive Team and Senior Staff developed a Strategic Map for the years 2008-2012. A copy of that map is attached. The overall goal of the ADH is to improve health and reduce disparities. Under that goal there are five Priority Areas:

1) Strengthen Core Services --(Family Planning, Prenatal Care, Immunizations, WIC, Home Health, etc.) by quality assessment, recommendations for improvement, implementation of those recommendations and re-evaluation.
2) Develop more Effective Population-Based Approaches --(injury prevention and control, reduce infant mortality, increase physical activity, and improve oral health).
3) Communicate Public Health Value and Societal Contribution --(economic development, public awareness, benefits of prevention).
4) Secure Adequate Human and Financial Resources --(workforce needs, workforce training, gaps, funding acquisition).
5) Increase Departmental Effectiveness and Accountability --(strengthen leadership, management systems, IT infrastructure, data utilization, accountability).

Cross-cutting all these areas are emphases on community engagement, partnerships, and policy development. The overall theme is to strengthen and improve traditional public health clinical services; and, at the same time, focus on several specific program developments, engage more in public awareness and policy developments, and retool administrative processes to work more effectively and efficiently.

Since 2008, ADH health services have been prioritized according to the strategic plan. Highest priority services are provided by ADH in all counties. Such services include Immunization, Family Planning, WIC, STI, infectious disease outbreak management, Breast and Cervical Cancer Control, and environmental health. Other high-priority services are provided not in the local clinics, but through the Central Office. These include newborn metabolic and hearing screening, and collaborations with Medicaid to assure enrollment in Medicaid and appointments with primary care physicians. Second priority services include basic preventive services for which availability is necessary in all counties, but for which local health systems may not have sufficient capacity. These include maternity care, maternal and infant home visiting and home health services. The maternal and infant home visiting program provides nursing assessment, teaching and referral for mothers and infants, to bridge the gap between hospital and continuing medical care in the community. This program served over 5800 patients in 2009. The remaining priorities include those preventive services that are optional for counties such as services for patients with diabetes and hypertension.

The Arkansas Department of Human Services (DHS) is a very large state agency which houses a number of programs of importance to maternal and child health. The Division of Medical Services conducts the Medicaid Program, which serves about 400,000 children at any given time. Of these children, about 325,000 are covered on the basis of income eligibility, known in Arkansas as ARKids First (ARKids A and ARKids B, depending on income level). Almost 30,000 women receive pregnancy-related Medicaid coverage each year. DHS is also home to the state Title V Children with Special Health Care Needs (CSHCN) program, which is found in the Division of Developmental Disabilities (DDS). CSHCN services are closely associated with specialty services of the Department of Pediatrics at UAMS. DDS additionally supports the state's early intervention services program (Part C). Another DHS unit, the Division of Children and Family Services, conducts programs to protect children who are abused, neglected, orphaned, or otherwise in need of basic care.

As the only medical school in the state, the role of UAMS in Arkansas's health care system is difficult to overestimate. Development of the College of Public Health within UAMS since 2001 has led to much stronger links between state health-engaged agencies and the university. UAMS is also the sponsoring entity for the Arkansas Center for Health Improvement (ACHI), a collaborative effort designed to promote public health research and translation into practice. UAMS supports ten Area Health Education Centers (AHECs) scattered around the state, which provide direct care and training of family medicine residents. The university's pediatrics and obstetrics/gynecology departments are very strong partners with ADH in the provision of direct care to women and children. These departments also partner with ADH to carry out ongoing public health programs and other initiatives to improve systems of care. A prime example of the latter is the Antenatal and Neonatal Guidelines for Education and Learning Systems (ANGELS) project, which is described more fully in later sections.

Although not state-supported per se, the role of Arkansas Children's Hospital (ACH) in the health system deserves special mention. ACH is one of the largest children's hospitals in the U.S., attracting patients from around the region and even other countries. ACH provides a large proportion of the pediatric critical care in the state. Apart from direct care provision, the hospital's administration is also committed to involvement in community- and state-level public health concerns such as infant mortality reduction, injury prevention, and school health initiatives.

The 77 general hospitals in the state provide the bulk of in-patient care. The Arkansas Department of Health works closely with these local providers to assure that standards of care are met. Apart from this regulatory relationship, at the systems level ADH also regularly partners with the Arkansas Hospital Association on issues of common interest.

Professional boards of Medicine, Nursing, and other disciplines are examples of other state agencies that provide support to the health system. These disciplines, along with dentistry, pharmacy, chiropractic, and hospital administration, are all represented on the Arkansas Board of Health.

Given the extreme problems of poverty, racial and ethnic inequality, and rurality inherent to Arkansas, the need for collaboration among health system stakeholders becomes evident at every turn. The many partnerships that have been developed in recent years to help promote and provide Title V-related services will be elaborated on in subsequent sections.

/2012/ The Overview of the State of Arkansas has not changed since the writing of last year's application. No additions or deletions are suggested. Please refer to the above information for the Overview on the State of Arkansas. //2012//

/2013/ The estimated population of Arkansas in 2011 was 2.94 million. According to census data, median annual household income in the state during 2006-2010 was $39,267, well below the comparable US median income of $51,914. //2013//

B. Agency Capacity

Arkansas has a variety of state statutes that guide the provision of services to mothers and children. There is no overall statutory authority for the MCH population, so existing statutes will be discussed within each of the sub-populations.

1. Primary and Preventive Services for Infants and Pregnant Women

Maternity services work to ensure all pregnant women in Arkansas have access to early and continuous prenatal care, thereby reducing the number of preterm and low birth weight infants and lowering infant mortality and maternal morbidity and mortality.

Target Population: Pregnant women in Arkansas, specifically those with no other source of prenatal care.

Description of Services: ADH Maternity clinics provide prenatal services, including risk assessments, laboratory, physical assessments, patient counseling, prenatal education classes, nutrition, social work counseling and referrals for high-risk care. Case management and follow-up ensures patients receive services needed. Medicaid eligibility is determined and, where possible, patients are referred to local physicians for continuance of care. All Local Health Units offer basic pregnancy testing and counseling, and referral to local physicians or to a neighboring Unit giving prenatal care. Working with the ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) program at UAMS, ADH anticipates implementing new screening methods for smoking, depression, partner violence and substance abuse. State law requires that all pregnant women be tested for HIV, unless they have been counseled and have refused the test.

All local health units provide pregnancy testing, prenatal counseling, and screening for presumptive Medicaid eligibility. The county health units work with nearby local health units and other care providers to ensure pregnant women have access to early prenatal care. Clients are provided referral information and accessibility to other ADH services, such as WIC and Immunizations. In 54 sites, located in 49 counties, ADH also provides prenatal clinic care that includes physical assessments, laboratory testing, genetic screening and counseling, prenatal education, nutritional counseling and education, WIC services, smoking cessation referrals and referrals as indicated for high risk care. ADH clinicians and public health nurses work closely with the University of Arkansas for Medical Sciences' perinatal program, ANGELS. With significant financial support from Medicaid, ANGELS provides evidence-based guidelines for maternal-fetal and neonatal care.

Maternity clinics in local health units may open or close as physician support wanes or waxes locally. However, prior to closure of a maternity clinic, earliness of prenatal care data from the community are always assessed to make sure minimum criteria are being met.

The Lay Midwife Licensor program, with ADH legal support and major input from licensees, oversees regulations pertaining to the practice of lay midwives. Those regulations last received major revisions in the spring of 2007. Program staff provides support, training, and assistance in continuing education to the 30 lay midwives currently licensed. Reporting forms for use by midwives are developed by the program and approved through the Arkansas Board of Health and Arkansas Legislature as required. Forms were last revised in 2008. Among other things, the forms provide information on deliveries provided by the midwives and any complications encountered. This information is then used to help assess training needs and to evaluate

midwives applying for re-certification, which is required every two years.

ADH operates a home health program called In-Home Services. Part of the care it provides is called the Maternal and Infant Program (MIP). MIP, if requested by a local health unit and approved by Family Health Branch medical staff, will make home visits to pregnant women at risk. For example, one at-risk group includes pregnant adolescents who would benefit from home assessment and further follow-up. In addition, MIP visits pregnant women who have medical complications such as pre-eclampsia requiring bed rest, diabetes requiring insulin therapy, or infants requiring special monitors or IV therapy. These visits are ordered by local physicians.

ADH continues to support the Healthy Baby/Happy Birthday Baby Book. Healthy Baby is a program of the Arkansas Department of Health that encourages all pregnant women to receive early and continual prenatal care. The Happy Birthday Baby Book can be requested by phone, internet or prepaid postcard.

Established in 1991, the ADH Resources and Health Information Line is a statewide, confidential, toll free information system that operates Monday-Friday, 8:00am to 4:30pm. It is staffed with employees trained to provide callers with public health and referral resource information. An electronic intranet resource is available to local health units through the ADH Intranet.

/2012/ ADH continues to provide direct provision on maternity services in 55 Local Health Units in 53 counties. In the five Public Health Regions, LHU sites and counties are routinely evaluated for the need to increase access of maternity services. ADH Women's Health Section contracts with the UAMS Department of OB/GYN to provide services beyond the scope of ADH including ultrasounds, genetic testing, high risk telephone and beginning in SFY2011 telemedicine consultations will be included. An interagency agreement with UAMS ANGELS to provide free access for the patients to call the 24/7 ANGELS Call Center when the local health units are closed is in process in the SW Region with plans to expand statewide. The goal is to reduce the emergency room visits for problems that can be triaged by the ANGELS Call Center.

The Health Resources and Services Administration; U.S. Department of Health and Human Services/ Maternal and Child Health has awarded ADH the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Grant. The areas that it will impact will be Crittenden, Lee, Mississippi, Monroe, Phillips, Jefferson and St. Francis Counties. This project will provide high quality home visiting programs that support the eight priority elements of the Maternal, Infant and Early Childhood Home Visiting Program. The national model chosen for replication in Arkansas is The Nurse-Family Partnership and will be developed in seven Arkansas Delta counties and activities will be provided by Arkansas Department of Health staff. The project was designed with input from the state's home visiting experts and program providers. This formula application includes measures for meeting federal benchmarks for maternal and child health. The program will be funded for federal fiscal years 2010-2014.

These funds have been made available under the home visitation grant funds under the Affordable Care Act of 2010. The Arkansas Department of Health (ADH) has been designated the lead state agency for this effort. A collaborative process for conducting a statewide needs assessment that has helped drive decisions regarding home visiting models and target communities has been conducted. Key stakeholders and partners include the Title V administrative unit within ADH, the Head Start State Collaboration Office, the Arkansas Children's Trust Fund (Title II/CBCAP agency), the Alcohol and Drug Abuse Prevention office within the Department of Human Services, Arkansas Children's Hospital (ACH), the Division of Child Care and Early Childhood Education, the University of Arkansas for Medical Sciences (Dept. of Pediatrics), the Home Instruction Program for Preschool Youngsters (state and national), the Parents as Teachers program, Arkansas Advocates for Children and Families, the Arkansas Department of Education, and a number of other public and private groups. Assessment of home visiting capacity within the state has been greatly facilitated by a survey of existing programs conducted by ACH and the Children's Trust Fund.

In accordance with the enabling legislation, Arkansas's needs assessment identified communities with high concentrations of maternal-child health issues (prematurity, low birth weight, etc.), poverty, crime, school dropouts, substance abuse, low academic achievement, domestic violence, unemployment, and child maltreatment. These communities will receive priority for home visiting services, as will individual families with histories of these issues. The Nurse Family Partnership model has been given primary consideration as the initial strategy for use of Year 1 and 2 project funds. However, other evidence-based home visitation models are being researched and will be considered for inclusion in the State Plan once the needs assessment is complete. An updated plan for addressing the needs identified in the assessment, along with a description and justification for the proposed program design has been submitted. This third submission of the application includes how the proposed model will meet the evidence-based criteria for addressing the identified needs and how the State will implement the program effectively and with fidelity to the model.
/2012//

/2013/ ADH direct maternity care service sites have increased to 61 local health units (6 additional sites) in 55 counties (1 additional county). ADH provides the initial prenatal visit to an average of 5,100 women annually. There is variability across the state in the length of time the patient continues to receive prenatal services through ADH. Approval for Medicaid is the primary reason the patient moves to a private provider. The Family Health Branch and the Center for Local Public Health have facilitated a collaborative partnership with the University of Arkansas for Medical Sciences Department of OB/GYN to provide telemedicine equipment and consultation/co-management services for ADH maternity patients at many local health units with future statewide expansion plans. //2013//

2. Primary and Preventive Services for Children

The purpose of the Child and Adolescent Health Program is to promote safe and healthy development of children so that all may achieve their full potential.

Target Population: Birth to age 21 for the State of Arkansas.

Description of Services: Child and Adolescent Health (CAH) currently comprises three major programs at the state level: newborn metabolic (blood spot) screening, newborn hearing screening, and Coordinated School Health. Other smaller programs such as SIDS grief counseling and limited lead poisoning prevention activities are also coordinated through this Section. Injury prevention activities, formerly a strong focus within CAH, were moved to a newly created branch within the Center for Health Protection in 2007. Abstinence education activities previously resident within CAH were suspended as of June 30, 2009 due to discontinuation of state and federal funding. Finally, at the local level, Immunizations and WIC constitute the primary programs available to children.

State statutes provide the legal basis for newborn metabolic and hearing screening. An important change to the newborn (metabolic) screening law occurred in 2005. At that time, the Arkansas Legislature mandated screening for cystic fibrosis and "other tests" as provided for through the Arkansas Board of Health. Prior to this time, each disorder screened for was mandated by a separate act of the Arkansas Legislature. Since the 2005 change in code, new disorders can be added on the authority of the Arkansas Board of Health alone. Thus, in 2007 the Board approved expansion of newborn screening to encompass all 28 metabolic disorders recommended for screening by the American College of Medical Genetics. To cover costs of the expansion, the Board also allowed for a large increase in the fee charged for screening. Expanded screening for all 28 disorders commenced July 1, 2008.

Rules and regulations governing newborn metabolic screening require birthing hospitals and other providers to obtain heel-stick blood specimens from newborns and submit them to the

Public Health Laboratory. The program's follow-up system is electronically linked to the laboratory data system, so positive results are automatically transmitted to follow-up nurses. Working under explicit protocols for each disorder screened, the nurses then convey the positive results and needed diagnostic testing to physicians by phone, fax, and regular mail. Follow-up contacts are then made at prescribed intervals to obtain results of confirmatory testing. In addition to this short-term follow-up, long term follow-up for infants diagnosed with a disorder through newborn screening (NBS) is conducted through five years of age. A somewhat unique feature of Arkansas's NBS program is the inclusion of an outreach nurse who provides regular scheduled visits to every birthing hospital in the state to provide training and updates on specimen collection techniques. A matching program developed within the Health Statistics Branch links birth records with newborn screening forms to determine the proportion of infants screened at each birthing hospital. This information, along with lab-generated hospital-specific data on percent of unsatisfactory specimens, is utilized by the outreach nurse at every visit to a hospital.

For infant hearing screening, the applicable Arkansas Statute (Act 1559 of 1999) mandates that all hospitals delivering over 50 babies a year conduct physiologic hearing screening on newborns and report the results to the ADH. In Arkansas, all current birthing hospitals deliver more than 50 infants per year, providing the potential for almost complete screening coverage. For both metabolic and hearing screening, parents are allowed to refuse screening, but historically very few refuse each year. Results of hearing screens conducted at hospitals are transmitted to program staff, who then follow up to assure that re-screens and/or diagnostic audiological testing are carried out. Program personnel are currently in the midst of preparing to change to an electronic system of follow-up that will be linked to the state's Vital Records (electronic birth records) system. With this new system (to be implemented in 2011), infants not receiving a hearing screen will be easily determined, and results and follow-up information will flow more efficiently in all directions.

Coordinated School Health activities are actually based at the Arkansas Department of Education (ADE). Since 2006, the ADH and the ADE Office of Coordinated School Health have partnered to support establishment of Coordinated School Health initiatives (CSH) in Arkansas. In 2006, nine pilot projects were established. That year, a CSH Coordinator was hired at ADH as a counterpart to a CSH Coordinator at ADE. In 2007, the ADH Tobacco Prevention and Cessation Program entered into a collaborative partnership with ADE to provide funding for an additional twenty-three school districts. At present, 33 school districts are involved in CSH. As part of Arkansas Act 180 of 2009, funds were allocated to establish 8-10 new school-based wellness centers. Only schools participating in the CSH initiative were eligible to apply for wellness center funding. In the spring of 2010, nine schools were selected to establish wellness centers, with implementation to proceed during the 2010-11 school year. As part of its continued support for CSH, ADH will soon hire a clinical coordinator to assist these schools in operation of wellness centers.

Other Child and Adolescent Health activities include grief counseling for parents of infants determined at autopsy to have died of SIDS. Title V funds support a small stipend to the State Medical Examiner's (ME) Office for provision of autopsies and autopsy information on babies who die suddenly and unexpectedly (usually at home). By Arkansas law, such infants should be transported in every case to the ME's Office for post-mortem examination. When a determination of SIDS is made, autopsy results are forwarded to CAH staff and parental counseling through the local health unit public health nurse is offered. A recently noted trend is that the ME is applying stricter criteria before making a determination of SIDS. Therefore, fewer babies have a death determination of SIDS, and more are being signed out as "sudden and unexplained infant death" (SUID). The Family Health Branch has recently been working with the ME's office in support of its efforts to train county coroners in proper infant death scene investigations.

Lead poisoning prevention carries no designated funding in Arkansas at present. Blood lead screens are conducted by private physicians in accordance with state and federal EPSDT rules. CAH provides occasional information to providers and parents on lead risks, and occasionally

helps arrange for an environmental investigation when a child is found to have a significant blood lead elevation. However, such occurrences have become extremely rare in the state. Recent screening data from Arkansas Children's Hospital suggest that the Medicaid population has only about a 0.3% prevalence of blood levels of >=10mcg/dL, with no levels exceeding 12 mcg/dL in the past year of screening at that institution.

At the local level, Title V provides support for a number of nursing and clerical positions working in local health units. These individuals provide WIC and Immunizations services, the chief child health services provided at the local level. At the state level, the WIC Program is administered through a separate branch in the Center for Health Advancement, while the Immunizations Program is conducted under the Infectious Diseases Branch in the Center for Health Protection. All staff members at the local level fall under the authority of the Center for Local Public Health, which is administered through five Regional Offices.

Although not part of Child and Adolescent Health, the Office of Oral Health (OOH) is an important ally in child health. OOH envisions Arkansas as a state where everyone enjoys optimum oral health through primary prevention at the community, health care professional and family levels. OOH believes this goal can be accomplished through accessible, comprehensive, and culturally-competent community-based oral health care provided through a variety of financing mechanisms; educational opportunities throughout life that will allow individuals to make better decisions for their health; and informed and compassionate policy decisions at all levels of government. In addition to improving dental health for infants, children, and adolescents, the Oral Health Office also strives to help adults and the elderly.

Description of Services: OOH colleagues provide education and awareness on a variety of oral health issues including fluorides and fluoridation, dental sealants, infection control, oral cancer, access to care, tobacco cessation and prevention, and family violence prevention. OOH assists communities with water fluoridation through community presentations and providing funding through the Arkansas Dental Foundation. Working with the Division of Engineering, OOH provides water plant operator trainings throughout the state. Working through the Arkansas Oral Health Coalition, OOH provides dental sealants to at-risk children. OOH has recently partnered with Arkansas Children's Hospital to provide both preventive and restorative care through utilization of three ACH mobile dental vans that traverse the state. OOH colleagues conduct a wide variety of assessment activities throughout the state on children, adolescents and the elderly. Reports on the various assessment activities are available and are combined into an oral health burden document. OOH also continues to support proposed legislation that would mandate fluoridation for all the state's public water systems.

/2013/ As above, funding for home visiting (MIECHV) received in 2011 through the Affordable Care Act has allowed for implementation of services utilizing a variety of home visiting models. MIECHV "formula" funding has provided for creation of Nurse-Family Partnership pods that will serve about 250 families in seven counties by the end of 2012. "Expansion" MIECHV funds received in 2011 are being used to establish a home visiting network and a training institute to meet educational needs of home visitors, and provide direct services to over 3,000 children and families statewide utilizing models such as Parents as Teachers, Healthy Families America, and Home Instruction for Parents of Preschool Youngsters.

Abstinence-only education activities have been re-initiated through CAH as a result of federal funds made available through the Affordable Care Act in late 2010. These activities are being carried out through a sub-contract with Healthy Connections of Mena, AR, a non-profit firm. Medical staff within the Family Health Branch reviewed available abstinence-only curricula and provided a short list of acceptable (evidence-based) curricula to prospective local abstinence-only sub-grantees. Currently 5 sub-grantees serve about 4,400 children and youth.

The electronic infant hearing module is undergoing user acceptance testing, with full rollout expected later this year. Coordinated school health is now present in 52 school districts. The ADH clinical coordinator for the school-based health centers established by ADE was hired in 2011 and is housed in the Center for Local Public Health. //2013//

3. Primary and Preventive Services for Children with Special Health Care Needs

Target population: Children and youth 0-21 years old with chronic illness, disabling conditions, or other special health care needs

Description of Services: The Title V CSHCN program provides direct health care services to approximately 500 children and youth in any given year who have applied for assistance in paying for eligible services. These services include coverage of diagnostic evaluations prior to subsequent eligibility determination being made. Referrals are made for other programs for which the individual or their family may be eligible. The coordination and payment of those services is accomplished by 4 Registered Nurses. Approximately 19% of those children and youth are undocumented and do not qualify for Medicaid because of their citizenship status. Therefore, the Title V CSHCN program has assumed the cost of care that is typically covered by Medicaid. Approximately 21% of the budget goes to those services. As funding allows, the Title V CSHCN program assists with families of eligible children and youth covered by Medicaid by paying for items or services not covered by the Medicaid state plan. Approximately 180 Medicaid recipients received assistance in the form of payment for items or services over the past year. Some of the assistance was for the purchase of van lifts, wheelchair ramps, overhead lift systems, and compounded drugs. In addition, the program has assisted in payment for attendance at Med-Camps during the summer. Attendance at these camps allows time for peer interaction and socialization while teaching diagnosis-specific self care in a fun, camp environment. The Title V CSHCN program set aside funds for a Family Support/Respite program. This program can provide assistance to families whose child has been determined disabled according to the SSI or TEFRA standards and whose care involves a service that is not covered by any existing program. The family can submit an application in which they detail the level of care required for their child in six areas of daily living. A physician must sign and verify that the parent has correctly outlined the level of care required for the child. Upon receipt, the application is reviewed for eligibility with a minimum number of deficits required to become eligible for the program. The services that can be provided are items (e.g. weighted vests, nutritional supplements) or services (e.g. respite). Last year the Title V Family Support/Respite program provided assistance to 354 CSHCN.
/2012/ The Title V CSHCN program continues to provide gap-filling services by paying for direct health care services. During the most recent year, the Title V program funded specialized services for 848 CSHCN. Of those, 328 had some coverage by private insurance and 184 (27%) had Medicaid coverage that did not meet their needs. 95 of the CSHCN were undocumented children/youth who do not qualify for Medicaid coverage. While accounting for only 11% of the number served (a decrease from last year), the cost of the care received was 25% of the budget spent. The Title V CSHCN program continues to pay for summer Med Camp and assisted 45 children to do so over the past year. The Title V Family Support/Respite program served 266 children during calendar year 2010 at a cost of over $248,000. During the first 6 months of calendar year 2011, Title V CSHCN staff coordinated an Autism Family Support grant funded by the Division of Developmental Disabilities Services. This grant brought many families into contact with our program and staff who had no previous history with the program. Over 850 applications were processed and families were also given information on the Title V CSHCN program as well as the Alternative Community Services Home and Community Based Waiver coordinated by the Division of Developmental Disabilities Services. Almost $1,500,000 in grant awards was dispensed by program staff.//2012//
/2013/ The program paid for services for 712 CYSHCN(avg cost $2985). 277 (39%) of these families had private insurance coverage. Of these 89 (12.5%) were undocumented at avg cost of care of $9025 or 38% of the budget. Also served were 166 Medicaid recipients (23%) for purchase of items outlined above. 53 CYSHCN were sponsored for Med Camps

as well as over $13,000 paid for respite services for CYSHCN whose parent serves active duty military at LR AFB.//2013//

Title V staff provide Medicaid-reimbursed care coordination assistance to approximately 1,700 CYSHCN and their families. The Medicaid recipient must be medically eligible for the Title V CSHCN program unless the individual is under age 16 and receives SSI or TEFRA benefits. Those recipients may request and receive Title V CSHCN care coordination assistance regardless of whether the diagnosis qualifies them medically for the program. The Title V CSHCN staff consists of RNs and Social Workers trained as a Title V CSHCN care coordinator and a medically trained Secretary who has received training and experience in care coordination. A broad-based knowledge of programs and providers of services in the state and local community allows Title V CSHCN staff to make appropriate referrals in a timely manner. Some of these referrals are for Special Needs Funds and Integrated Supports, DDS programs that provide timely relief to families with emergency needs. Title V CSHCN personnel also make referrals and assist with applications for the ACS Home and Community Based Waiver. This task requires a great deal of time and, typically, multiple contacts with the parent/guardian and other entities to obtain the information required for the application. The waiting list for the ACS Waiver is quite long and Title V CSHCN workers are often contacted when emergencies occur due to behaviors at school and/or home. The CSHCN team works in concert with other DDS programs to assist the family in obtaining services for immediate needs.

/2012/ Over the past year, Title V CSHCN caseworkers have provided care coordination services for approximately 2,300 CYSHCN and their families. During the same period of time, Title V caseworkers assisted approximately 1,000 families in the application process for the Home and Community Based Waiver commonly known as the DDS Waiver. Title V CSHCN caseworkers utilize contractors for translation and interpretation services to communicate with parents/guardians who do not speak English. In addition, community support organizations with interpreters are often used by the parent/guardian when making contact with CSHCN program staff. All correspondence with this population is translated. Other correspondence/notices, such as the Transition Tip sheets are translated as well. //2012//

/2013/ Care coordination services provided on behalf of 3,495 during the past year. Staff assisted 1,200 of that number to apply for the DDS Waiver.//2013//

Mental health services for children and adolescents in Arkansas come from a variety of sources. Many private providers, particularly those with inpatient facilities, receive state assistance to help care for emotionally and behaviorally disturbed youth. Inpatient programs often have specific treatment units for issues such as substance abuse, sexual offenses, mood disorders, and various forms of psychosis. These providers work closely with regional CASSP coordinators and local CASSP teams, including Title V CSHCN program staff, to determine the most appropriate placement of affected children and youth within the state network of providers. The CASSP Coordinating Council, consisting of representatives of mental health providers, regional CASSP coordinators, and other agencies including Title V CSHCN, meets monthly to share information and discuss system issues. A more recent infrastructure-building effort is the System of Care initiative being carried out by Division of Behavioral Health Services within DHS.

By agreement with Arkansas Social Security Disability Determination Services office, information is forwarded to the Title V CSHCN program when they receive an application for SSI on any child or youth less than 16 years of age. Upon receipt, CSHCN staff review each referral to determine if the individual is already receiving Title V CSHCN services. If not, further referrals are made for other services/programs for which the individual may also be eligible, such as Part C Early Intervention, DDS programs and Behavioral Health services. Approximately 2,000 such referrals are received during any given year.

/2012// Arkansas was awarded a D70 CYSHCN System of Services grant effective 7/1/11. The grantee is Arkansas Children's Hospital Research Institute (ACHRI) with co-Directors Dennis Kuo M.D. and Eddie Ochoa M.D. ACHRI will work in partnership with the Title V CSHCN program, the

Family 2 Family Health Information Center of Arkansas and the Arkansas chapter of the American Academy of Pediatrics during the grant period. The proposal focuses on family and provider training, resource development and direct outreach to families and providers. It includes capacity building for Title V staff on medical home and transition. Specific initiatives include: developing a state consortium for CYSHCN, which creates and assists in implementation and evaluation of a strategic plan for developing the system of care; a full-time Minority Outreach specialist at the F2F; a web-based directory of county and state resources for CYSHCN; learning collaboratives and quality improvement initiatives for six pediatric practices; and resource development and training on transition to adult health care. //2012//

/2013/ A newly named AR system Improvement Project (ARSIP) is now fully staffed with multiple stakeholders statewide. Monthly consortium meetings are held with up to 25 representatives of state agencies, community groups and families. The consortium held a day-long strategic planning meeting that included 10 family members and additional program staff. Statewide focus groups were done to gather input into the strategic plan with publishing of the plan anticipated later this year. Health care transitions for YSHCN is a focus with an active Transition Committee. The grant brought Dr. Carl Cooley to AR for a Grand Rounds presentation and meetings with staff and stakeholders in early June 2012.//2013//

4. The WIC population

The mission of the Women, Infant and Children program (WIC) is to improve the health of infants, children and childbearing women by directly supplementing their diets with foods rich in nutrients they need, providing nutrition education and counseling and referrals to other services. The mission of WIC Farmers' Market Nutrition Program (FMNP) is to encourage the consumption of fresh fruits and vegetables by WIC participants and encourage the development of farmers' markets.

Target Population: Pregnant, breastfeeding and postpartum women, and infants and children under age five are eligible if they live in Arkansas, are income eligible and have a condition or living situation which places them nutritionally at risk. Income eligibility is based on 185% of the federal poverty guidelines. For FMNP, women and children who are WIC participants in the counties with authorized farmers' markets are eligible.

Description of Services: Risk Assessment - a screening to determine nutritional status is performed on each applicant by a nurse, nutritionist, home economist, or physician.
Food: WIC participants receive nutritious, prescribed foods and purchase these foods as listed on WIC checks (bank drafts) at local grocery stores. The WIC food package was updated in October 2010 to include the addition of fresh and frozen fruits and vegetables, soy beverages, whole grains, and infant foods. FMNP participants receive coupons, not to exceed $12, to purchase locally grown fruits and vegetables at authorized farmers' markets.
Nutrition Education:
•Nutrition Counseling --Participants with potentially serious nutrition-related health problems are scheduled for individual counseling by nutritionists.
•Nutrition Education --All participants or parents of participants are offered nutrition education designed to improve health status and achieve positive change in dietary and physical habits.
•Breastfeeding Promotion and Support --All pregnant women receive breastfeeding promotion and education to enable them to make an informed decision about how to feed their baby. Support is made available to breastfeeding women and infants by trained staff, breastfeeding peer counselors in select counties and through the breastfeeding helpline. Breast pumps and other tools are available to support breastfeeding mothers when a need is identified.

Referrals to Other Services: WIC participants are referred to other services as needed by local clinic staff. Strong emphasis is given to childhood immunizations and prenatal care.

5. Women and men of reproductive ages (Family Planning)

The purpose of the Reproductive Health Program is to provide reproductive health services to women and men, enabling them to choose the number and spacing of children and prevent unplanned pregnancies. Reproductive Health services include health history assessment, laboratory tests, physical assessment, contraceptive methods, health education, treatment and referral. Clients are also strongly counseled on immunization needs. The Reproductive Health Program has implemented health records specifically for male clients seeking reproductive services. These services are available to all Arkansas residents at 84 Local Health Units (LHU) and one (1) contracted agency.

Target Population: Men and women of childbearing age in the State of Arkansas, primarily low-income clients who are uninsured and under-insured. Priority populations include teens, minorities, low income women, women without insurance, and unmarried women.

Description of Services: The Reproductive Health Program provides, through ADH and delegate agencies, clinic based family planning services to women and men in need of publicly supported services. Eighty percent of clients are at or below 200% of poverty according to declared income and family size. In addition, the program provides outreach and education to hard-to-reach populations regarding family planning. This includes education on abstinence and male responsibility. The program also detects precancerous and cancerous changes of the uterine cervix through Cervical Cytology Screening.

The Reproductive Health Program is a Title X Grantee. The program also benefits from the Women's Health Waiver, which is a Medicaid 1115 Waiver Program for family planning services in Arkansas. All women of reproductive age that have incomes at or below 200% of the federal poverty level are eligible for the waiver.

/2012/ The ADH Title X family planning program continues to provide services intended to assist individuals in determining the number and spacing of their children. This promotes positive birth outcomes and healthy families. The education, counseling, and medical services that assist individuals and couples in achieving this goal is now available in 89 Local Health Units and 4 Delegate sites. The Title X Delegate sites which include clinic settings are located at the University of Arkansas at Pine Bluff and Central High School in Little Rock. The two Delegate agencies at which family planning education and counseling are located at the Ouachita Children's Center in Garland County and the Wilbur D. Mills Substance Abuse and Treatment Center in White County. The ADH family planning program includes policies to address the Title X priority on the importance of counseling family planning clients on establishing a reproductive life plan, and providing preconception counseling as a part of family planning services. //2012//

/2013/ The ADH Family Planning Program, within the Family Health Branch, continues to work closely with the Center for Local Public Health to maximize family planning resources. We continue our efforts to provide comprehensive family planning and related preventive health services to the priority populations who want and need them. Efforts include partnering with communities and local and state health and social service organizations. The number of ADH family planning services sites increased from 88 to 95 compared to CY 2010 due to the creation of satellite sites at local colleges. The two Title X Linkage projects were not identified as non-discretionary sub-grantees in the 2012 NOA. A "Request for Applications" is anticipated for bids to provide Title X services to select high risk populations these facilities had previously served. Funding, through the U.S. DHHS Family and Youth Services Bureau Administration for Children and Families was awarded to ADH for the fiscal years 2010 through 2014 for the Personal Responsibility Education Program (PREP). The target area for the PREP program is for youth in foster care in Pulaski County. The implementation of PREP activities began January 2012 and is provided by a grantee selected by the RFA state application process. The efforts focus on delaying/reducing the incidence of pregnancy through implementation of strategies that

provide age-appropriate materials for youth (i.e. evidence based curriculum facilitation) and empower youth regarding ways to build self-esteem, strengthen communication and cultivate education and career success. The ADH and sub-grantee have developed memoranda of agreements with the AR Department of Human Services, Division of Children and Family Services to provide support for PREP by increasing access to and augment services for foster care adolescents. //2013//

6. Target population: Medicaid Recipients

The Health Connections Section (HCS) in Family Health, through a toll-free hotline, communicates with new enrollees in Medicaid to link the children to a Primary Care Physician (PCP), and to case manage them for initial dental appointments. Up-to-date lists of physicians, dentists, and enrollees are maintained by Medicaid and HCS is provided with updated computer databases to track and inform newly enrolled families. HCS also provides through its health education staff community based outreach education to promote Medicaid use by adolescents in the school setting.

C. Organizational Structure

Since July 1, 2007, when the Arkansas Division of Health separated from the Arkansas Department of Health and Human Services to again become the Arkansas Department of Health (ADH), great strides have been made in restoring agency infrastructure. The State Health Officer, Dr. Paul Halverson, reports directly to the Governor as a Cabinet member. ADH is now organized into five primary Centers: Health Advancement, Health Protection, Public Health Practice, Local Public Health, and the Public Health Laboratory (see attached ADH organizational chart). The Family Health Branch is located within the Center for Health Advancement, along with four other branches: Nutrition/WIC, Oral Health, Life-stage Health, and Chronic Disease. Within each branch, various sections carry out specific programmatic and administrative functions. The Family Health Branch contains three sections: Women's Health, Child and Adolescent Health, and Health Connections.

Title V CSHCN program activities have historically been housed within the Arkansas Department of Human Services (DHS). DHS is a large separate agency whose director, Mr. John Selig, also reports directly to the Governor (see DHS organizational chart, second page of attachment). DHS consists of ten major divisions. The Title V CSHCN Program is housed within the Division of Disabilities Services (DDS). The director of this division is Charlie Green, PhD. DDS also contains administrative units for Early Intervention Services (Part C) and direct and coordinating services for children and adults with developmentally challenging conditions.

Administration of Title V grant activities is therefore a collaborative process within the state of Arkansas. As the primary grantee, ADH apportions funds to the CSHCN Program at DHS based on a mutually agreeable formula. Program personnel from the two state agencies work together throughout the funding cycle to assure that grant funds are expended in accordance with federal and state requirements.

/2012/ The organizational structure described above has not changed. //2012//

/2013/ In 2011, the Tobacco Prevention and Cessation Program was moved back under the Center for Health Advancement, joining the other branches listed above. Even more recently, the Lifestage Health Branch has been merged into the Chronic Disease Branch. The attached ADH organizational chart reflects these changes. //2013//

/2013/ Recently, the Coordinated School Health Program moved from the Lifestages Branch to the Child and Adolescent Section within the Family Health Branch. This puts the Coordinated School Health Program under direct administration of the Title V staff. The Lifestages Branch has been incorperated into the Chronic Disease Branch. //2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The Family Health Branch Chief position was recently vacated by Dr. Richard Nugent, who had served as Director of Maternal-Child Health Activities at ADH for almost 18 years (see attached branch organizational chart). In anticipation of Dr. Nugent's retirement, recruitment for this position has been underway for some time, and a replacement is likely to be named very soon. Mr. Bradley Planey, a long-time ADH administrator in family planning and current Associate Branch Chief, has recently accepted the role of Interim Title V Director. Mr. Planey holds an MS in Rehabilitative Counseling, an MA in Human Resource Development, and an MA in Health Services Management and has previous career experience in rehabilitative services. Dr. Bob West, a board-certified pediatrician with over 15 years experience at ADH, serves as Deputy Chief for Family Health. Dr. West has a Master of Public Health degree (MPH) and has past experience both in academic medicine and in medical care for those with severe developmental disabilities. Data analysis for MCH is provided by Ms. Terri Wooten, an epidemiologist housed in the Health Statistics Branch who recently completed work on her MPH degree. Ms. Wooten has been invaluable in providing statistics and analysis related to the Block Grant, Needs Assessment, and any other MCH data needed for special projects such as infant mortality reduction.

/2012/ Dr. David Grimes was hired in July 2010 as Family Health Branch Chief. Dr. Grimes has a Master of Public Health degree (MPH) and is board certified in both OB/GYN (FACOG) and Preventive Medicine (ACPM). Dr. Grimes has 30 years experience in OB/GYN private practice and has been the medical director of county health departments in Illinois and Kentucky. The agency has decided to split the role previously performed by Dr. Nugent as the Director of Maternal-Child Health activities at ADH. Mr. Bradley Planey is serving as the Title V Director, having responsibility for the MCH Block Grant and its management, while Dr. Grimes is filling the role of Maternal-Child Director, leading the agency in maternal-child activities and partnerships in the state. //2012//

Other MCH data support is provided by various analysts in the Health Statistics Branch (HSB). This branch manages data from birth and death certificates, hospital discharge, PRAMS, BRFSS and local YRBS databases. HSB also manages professional registries for licensed health professionals. HSB maintains a staff of highly skilled statisticians who are trained in SAS software use. They assist epidemiologists and program directors with data needs for agency performance, strategic planning, and program registries such as cancer and immunization. The HSB manages the State Systems Development Grant (SSDI) which supports a rich network of data linkages being developed by the Arkansas Health Department. For example, SSDI and other resources have enabled HSB to link birth certificates to infant death certificates, hospital discharge data, PRAMS survey data, Medicaid enrollment and billing information, and a variety of other data sets.

MCH capacity for populations of interest are described below.

1. MCH capacity for pregnant women and infants

The Perinatal Program is a part of the Women's Health Section within the Family Health Branch. The Perinatal Program provides support and guidance to the public health units through research, policy development, and directing and assisting implementation of program policies and procedures. Women's Health Perinatal staff includes a chief physician consultant (Dr. Michael Riddell), who is board certified as a Fellow of the American College of Obstetrics/Gynecology, and a Section Chief (Sharon Ashcraft), a BSN Registered Nurse with extensive experience in maternal child care and public health. A total of 11 staff members at the state level support Women's Health program administration, which includes both maternity and family planning operations. At the local level, Advanced Practice Nurses and Registered Nurse Practitioners,

along with the public health nursing staff, provide direct clinical services in accordance with program guidelines.

/2013/ At the state level, the Agency's support of the programs for pregnant women and children has remained firm. The Women's Health Section hired Rhonda Kitelinger for the vacated maternity program nurse position. Rhonda is an R.N. with extensive experience in maternal and child care both in the private and public sector. At the local level, a total of 40 full time and 2 part time Nurse Practitioners provide women's health and preventive services. Thirty-six of those NP's provide maternity services working under the guidance of Dr. Michael Riddell, ADH Physician Specialist, FACOG. The Family Health Branch and the Center for Local Public Health have facilitated a collaborative partnership with the University of Arkansas for Medical Sciences Department of OB/GYN to provide telemedicine equipment and consultation/co-management services for ADH maternity patients at many local health units with future statewide expansion plans. //2013//

2. MCH capacity for children

The Child and Adolescent Health (CAH) Section of the Family Health Branch houses children's health programs. Ms. Millie Sanford, a licensed audiologist with a Master of Science degree, who has served children in this agency for over 15 years, was appointed Section Chief for CAH in March 2010. As before, Family Health Branch leaders expect the Section to continue emphasizing development of interagency collaboration and broad partnerships in improving services for children. Heavy use of MCH Block Grant dollars to sustain the immunization program continues, but greater emphasis is being brought to Coordinated School Health, Early Childhood Comprehensive Health Systems, and newborn metabolic and hearing screening. A total of 25 nurses, program managers, audiologists, and administrative and clerical staff currently carry out CAH functions at the state level. Funding for these positions comes from a variety of sources: newborn screening fees, MCH Block Grant, state general revenue, federal categorical grants for infant hearing, and a cooperative agreement with the Arkansas Department of Education (for Coordinated School Health).

/2013/ Patricia Scott, DNP, CPNP, was hired in May 2011 to assume the role of Nurse Manager for the newborn screening program as well as to provide oversight for other child health programs including school health and other special projects. Dr. Scott brings a wealth of experience in direct pediatric service provision and academic nursing and will undoubtedly shape the direction of many child health programs in coming years. //2013//

3. MCH capacity for Children with Special Health Care Needs

The Title V CSHCN program (formerly known as Children's Medical Services or CMS) currently resides within the Division of Developmental Disabilities Services (DDS) at DHS. Ms. Nancy Holder, an RN with many years experience in CSHCN service delivery, directs the program. Ms. Holder and Iris Fehr, RN oversee the work of nurse care coordinators serving children with a variety of medical conditions (e.g. diabetes, cancer, severe asthma, orthopedic conditions, spina bifida, and/or cystic fibrosis). Eldon Schulz, M.D., with the University of Arkansas for Medical Sciences Department of Pediatrics, serves under contract as Medical Director for the Title V CSHCN program. His professional background is in Developmental-Behavioral Pediatrics.

The Title V CSHCN program currently has on staff: 18 Clerical Staff, 15 Registered Nurses, and 6 Social Workers in community-based offices. There are six Management staff with two housed in community-based offices and four in the central office. There are eleven Central Office support staff (administrative and clerical). Of the 55 total employees, seven have children/grandchildren with special health needs. One is the Parent Consultant, three are Clerical staff, two are Registered Nurses, and one is a Social Worker.

/2012/ The CSHCN program is currently experiencing a shortage in casework staff. 26% of the

Registered Nurse positions and 33% of the Social Work positions are vacant. Although a small number of the vacancies are due to resignations for job change, the vast majority of the vacancies are due to retirement of long-term employees. This trend is expected to continue over the next several years. In a recent employee survey, 60% of the respondents had been employed with the program over 10 years. In an effort to expand parent involvement in the CSHCN program, two grants have been initiated over the past year. The first grant from the CSHCN program is to the Project DOCC (Delivery of Chronic Care) program coordinated through the Parent Advisory Council. Project DOCC has seen funding assistance wax and wane over the years and, the grant was begun in order to provide a more stable financial environment for the program. Project DOCC facilitates a meeting between a resident physician at the University of Arkansas for Medical Sciences and the parent of a CSHCN. The meeting involves an interview during which the parent explains how the needs of the CSHCN influence the day to day life of the child and family. The goal is to increase the physician's awareness of how the needs of the child and the treatments ordered, no matter how seemingly minor, can have a significant impact on the family when put into practice. The second grant from the CSHCN is to the Family to Family Health Information Center established by a HRSA grant in 2009. The initial grant funds are used to fund the Project Director full time and 5 regional coordinators 8 hours per week. The Title V CSHCN grant enables the regional coordinators to work an additional 2 days per week. //2012//

Rodney Farley serves as Parent Consultant for the Title V CSHCN program. In this position he serves on a number of committees as a parent of a child with special needs and as an advocate. The committees he serves on include Partners for Inclusive Communities (Arkansas' Center for Excellence in Disabilities) Consumer Committee; Arkansas Parent Information Exchange; Arkansas Children's Hospital Rehab Advisory Committee; Family to Family Health Information Center Governing Board; AR Can-Do Committee. He serves on the board of directors for the AR State PIRC/Center for Effective Parenting; and the Board of Directors of the Disability Rights Center (Arkansas protection and advocacy services for people with disabilities). Nationally he serves as co-chair of the AMCHP Family and Youth Leadership committee. Rodney works with the Title V CSHCN Parent Advisory Council (PAC). As the parent of a young adult with special health care needs, he is able to give advice and assistance to parents with children of all ages. The Parent Advisory Committee (PAC) for the Title V CSHCN program was formed 20 years ago and involves volunteers from around the state that are parents of CSHCN. The PAC meets quarterly. The PAC members are responsible for setting up local meetings to take information to more parents and work to set up support groups around the state.
/2013/ The CSHCN program has been able to fill 4 RN vacancies recently. The placement of new staff has increased the referral activity within those regions of the state. A Grant was renewed with the Parent Advisory Council for Project DOCC.
The Title V CSHCN program has also worked very closely over the past year with two partners funded by HRSA and MCH. The Systems Improvement Grant for CSHCN, newly named Arkansas System Improvement Project (ARSIP) is now fully staffed. ARSIP has a lead role in Arkansas for addressing health care system needs relating to CYSHCN. ARSIP continues to work closely with its subcontractors, including Title V CSHCN; Arkansas Family-2-Family Health Information Center (F2F); and the Arkansas chapter of the American Academy of Pediatrics (ARAAP). All of the subcontractors attend the monthly consortium meetings and the ARSIP staff meets with the subcontractors individually on at least a monthly basis. ARSIP staff have built a particularly close relationship with Title V CSHCN and collaborated on presentations, survey design and collection, and family needs assessments.

Strategic relationships have been built between project staff and Arkansas CYSHCN Stakeholders. ARSIP leads a monthly CYSHCN consortium meeting of 15 to 25 persons representing multiple state agencies, community groups, and families. ARSIP staff regularly meets with individual stakeholders one-on-one to introduce the project, identify mutual goals, and invite them to the consortium. In the spring of 2012 the consortium developed a statewide strategic plan for system of care needs for CYSHCN in Arkansas, culminating in a day-long strategic planning meeting that addresses the current Title V

Needs Assessment and the Maternal and Child Health Bureau (MCHB) Core Outcomes. The F2F worked closely with the D70 project team to conduct a series of four family-based focus groups around the state (including one group conducted entirely in Spanish) in order to give minority and underserved families the opportunity to discuss at length the challenges that their families face in getting proper healthcare for their children. The focus groups content will refine the strategic plan, which will be published after a brief public comment period.

The ARSIP has successfully recruited key stakeholders to address the topic of youth health care transitions. ARSIP has formed a transitions work group that meets monthly. Current attendees represent Arkansas Children's Hospital, University of Arkansas for Medical Sciences, and the Title V CSHCN work group. The transition work group has identified a number of transitions tools, developed a logic model for promoting health care transitions, and had a consultation visit from Dr. Carl Cooley of the Got Transitions center. The ARSIP transitions group is also collaborating with a new transitions work group with Title V, families, and representatives from Arkansas Children's Hospital.

The Title V CSHCN program provides financial support to the Family 2 Family Health Information Center. Over the past year, many successes occurred with F2F including: F2F staff was complete with the hiring of a full-time Minority Outreach Specialist. The Specialist set up a Spanish-version of the F2F Facebook page and began sharing F2F-related information with many contacts in the Hispanic community in central AR. Minority Outreach Specialist began translating a number of F2F-related resource materials into Spanish, including the creation of a Spanish F2F flyer that is used to create awareness of the F2F program in Hispanic homes around Arkansas. The F2F program began reaching to a number of existing organizations that work with minorities and underserved families in order to establish a network of collaborative partners. So far these partners include: AR Minority Health Commission; AR Support Network; AR Children's Hospital; Disability Rights Center of Arkansas, AR Home Visiting Network; Statewide Parent Advocacy Network; and the National Center for Cultural Competency at Georgetown University.
In May, a grant from Family Voices funded a technical assistance trip to New Jersey, where they met with the New Jersey F2F and received two days of intensive training on minority outreach and cultural competency. The five F2F Regional Coordinators began an environmental survey of their respective part of Arkansas to identify what minority outreach capabilities and programs that
health-related organizations, programs, institutions, and individuals currently have available.
The F2F is also working with the University of Arkansas' Clinton School of Public Service to create a Capstone Project that will allow a UA student to assist the F2F in creating an on-line resource directory of organizations, services, specialists, therapists, programs, parent support groups, etc. that families in Arkansas can use to locate the health-related services that they need for their children. This resource directory project will work in tandem with other similar efforts currently underway by UALR and UAMS.
The F2F also helped to sponsor a Sibshop training event in April, presented by the nationally-known Don Meyer. The F2F is a core partner in helping to develop a statewide Sibshop network in Arkansas.
The F2F is also working with the Arkansas Can Do organization to help promote children's health, sensitivity training regarding individuals with disabilities and helping to promote People First Language.//2013//

4. WIC services

As mentioned, the WIC Program is a separate branch within the Center for Health Advancement. WIC clinic services and food instrument services are provided in all local health unit sites. In addition, three WIC-only sites (in Springdale, Fort Smith, and Lowell) also provide services. Ms.

Susan Handford, a nutritionist and experienced WIC administrator, is the interim director for WIC following the retirement of the former director. The WIC Program is supported by the Center for Local Public Health, which assures program operations through Regional Directors and Local Health Unit Administrators.

/2012/ The interim director for WIC, Ms. Susan Handford, a nutritionist and experienced WIC administrator, has been named the WIC Director. //2012//

E. State Agency Coordination

State agency coordination exists on many levels, including 1) among state government human service agencies, 2) through state-level commissions and other state-level partnerships, 3) through state-local health agency relationships, and 4) via local human services agency interactions. Each of these categories of coordination is discussed separately.

1. State government human services agencies

The three main human service agencies - the Arkansas Department of Health (ADH), the Arkansas Department of Human Services (DHS), and the Arkansas Department of Education (ADE) - are all cabinet-level agencies whose directors report to the Governor. As sister agencies, cooperation and collaboration are expected by the Governor and Arkansas Legislature, to the fullest extent possible.

The most obvious example of coordination between ADH and DHS relative to MCH services is, as previously described, the collaboration needed to carry out Title V with activities split between the two agencies (see attached MOA). Another specific example of collaboration between ADH and DHS is the contract with the DHS Division of Medical Services (Medicaid) to support the ConnectCare program, which is conducted by the ADH Health Connections Section. ConnectCare links new and established Medicaid participants with primary care physicians and dentists. The program also provides helpful information to Medicaid beneficiaries through a newsletter and other educational tools. The Medicaid Family Planning Waiver is another collaborative activity. This expansion of eligibility affords family planning services to women who previously would not have qualified for Medicaid. Family Health staff members contribute parts of the required triennial renewal application and participate in quarterly conference calls. Other agreements between ADH and DHS that are smaller in scope also abound, but are equally important. For example, a memorandum of agreement between the ADH Infant Hearing Program and the DHS Early Intervention (Part C) program provides for exchange of follow-up information after babies diagnosed with hearing loss are referred to Part C.

As for ADE, a number of working relationships with ADH also exist. Part of ADH's appropriation from the tobacco master settlement funds goes toward employment of 23 Community Health Nurse Specialists (CHNSs) and Community Health Promotion Specialists (CHPSs). The CHNSs are primarily involved in tobacco use prevention in schools and communities, while the CHPSs focus more heavily on anti-obesity efforts related to Arkansas Act 1220. Although employed by ADH, the CHNSs and CHPSs are housed in the 15 Education Service Cooperatives around the state per agreement with ADE. ADH also provides funding to support the ADE School Nurse Consultant, who receives co-supervision by ADE and ADH. The Coordinated School Health Coordinator position housed at ADH is funded by the Arkansas Department of Education, but supervised by ADH alone. A similar position to coordinate clinical activities at the newly established school wellness centers is also being created. It is anticipated that this position will be funded by ADE but housed and supervised by ADH.

2. State-level commissions, and other state-level partnerships and advocacy groups

Among many such groups, a few stand out as being particularly important. One longstanding partner is the Commission on Child Abuse, Rape and Domestic Violence. Among many other activities, this group has worked to establish a child fatality review process in Arkansas. Members of the ADH Family Health team have participated in these efforts. The Child and Adolescent Service System Program (CASSP) strives to improve the system of care for children and youth with mental and behavioral health issues. Dr. West serves on the CASSP Coordinating Council, which meets monthly. Another group, the Interagency Coordinating Committee (ICC) was established for IDEA and continues to help state agencies collaborate around the educational and health needs of at-risk children. Finally, the non-profit Arkansas Advocates for Children and Families has played a major role over the years in public policy for the needs of children in general. Arkansas Advocates' personnel serve on a large number of important interagency commissions, coalitions, and other state-level planning groups.

Another important state-level group is the Arkansas Early Childhood Comprehensive Systems partnership, which has devoted much effort to development and implementation of a Quality Rating System (QRS) for child care and early childhood education providers. A five-tiered QRS for all aspects of child care and early education that includes a comprehensive set of criteria for health issues has, after thorough review by important stakeholders, been settled upon. The Division of Child Care and Early Childhood Education (DCCECE), the licensing unit within DHS, has assumed leadership for applying these voluntary guidelines. Until his recent retirement, Dr. Nugent served as co-chair for the AECCS Medical Homes Committee, which has nearly completed development of a medical homes "tool kit" for use by child care providers. In addition to Medical Homes, other AECCS committees include Social/Emotional, Early Childhood Education, Family Support, and Parent Support subgroups. Providing oversight to the entire AECCS process is the newly established Arkansas Early Childhood Partnership Council. Finally, a related state-level body is the Early Childhood Commission (ECC), which provides guidance to DCCECE. Dr. West currently serves on the ECC as the ADH representative.

The Child Health Advisory Committee (CHAC) was created through Arkansas Act 1220 of 2003 to address childhood obesity and develop statewide nutrition and physical activity standards. The Committee, which is now staffed by the LifeStage Branch within the ADH Center for Health Advancement, meets monthly and makes policy recommendations to the State Board of Education and the State Board of Health. Major tasks mandated by the original Act include: 1) Removing elementary school student in-school access to vending machines offering food and beverages; 2) Developing recommendations to ensure that nutrition and physical activity standards are implemented to provide students with the skills, opportunities and encouragement to adopt healthy lifestyles; 3) Requiring schools to include as part of the annual report to parents and the community the amounts and sources of funds received from competitive food and beverage contracts; 4) Requiring schools to include an annual measurement of body mass index (BMI) percentile as part of each student's health report to parents; and 5) Requiring schools to annually provide parents an explanation of the possible health effects of body mass index, nutrition and physical activity. The Committee includes state-level representation from public schools, nutrition, pediatrics, public health, family medicine, physical activity, cooperative extension service, school nurses, the PTA, child advocates, and other relevant groups. The CHAC has seen many of its recommendations translated to policy within the education system. As a result of amendments to Arkansas Act 1220 in 2007, CHAC is now also charged with providing guidance for the Coordinated School Health Program. Another amendment that year changed the frequency of BMI measurements in schools to every other year (even-numbered grades K-10). Dr. West serves as the ADH representative to CHAC.

The Natural Wonders Partnership Council is yet another major interagency coordinating and advocacy effort underway. Initially envisioned by the leadership at Arkansas Children's Hospital (ACH), the effort has grown to include virtually all groups at the state-level with an interest in improving child health status. ACH now has full-time staff dedicated to continuing the process, which began with a multi-pronged statewide needs assessment in 2007. Since then specific action groups for such issues as infant mortality, oral health, and coordinated school health have

blossomed and continue to thrive. ADH has had representatives on all of these groups; for example, Dr. Jennifer Dillaha, former Director of the Center for Health Advancement, has chaired the infant mortality action group. Natural Wonders assessment and intervention activities are described further in the 2010-15 Needs Assessment document.

/2013/ The Natural Wonders Partnership Council, now includes Bradley Planey, Title V Director and Family Health Associate Branch Chief. This insures MCH and the ADH are represented in this important partnership. //2013//

/2012/ New activities include ADH coordination with March of Dimes (MOD) for the 2013 Arkansas launch of the Healthy Babies are Worth the Wait (HBWW) campaign. This will focus on eliminating near term non-medically indicated deliveries (inductions and repeat C/S) before 39 weeks. Arkansas Newborn Intensive Care Units (NICU) level designations are being developed (Arkansas is 1 of only 3 states with no NICU level designation). Preterm infants < 1,000 gm [< 28 wk] have 50% less mortality if delivered at a hospital with a level III nursery compared to being transported after delivery. Patient and physician education programs are being developed. Community education for evidence based programs to reduce Infant Mortality Rates (IMR) is being continued and improved (Back-To-Sleep and Folic Acid supplementation before pregnancy), Text4baby is now available to all Arkansas pregnant women and families with an infant less than 1 year old as a free cell phone texting service that provides them with 3 free text messages each week with health information geared to their gestational age or the age of the infant (reminders of when immunizations are due and to take prenatal/folic acid vitamins). Sudden Unexpected Infant Death (SUID) scene investigation training is continuing for First Responders because of continued employee turnover and election of new county coroners. //2012//

/2013/ The Infant Mortality Action Group has continued to meet and is finalizing a state strategic plan. Other infant mortality activities mentioned above are also proceeding. An NICU designation and regionalization committee has been formed at the request of the ADH Director to provide recommendations to him later this year. Representatives include birthing hospitals of all sizes, neonatologists, perinatologists, March of Dimes, medical society and hospital association representatives, and key ADH staff. ADH is also coordinating with MOD on the HBWW campaign and has sent a letter to all delivering physicians in the state apprising them of the problem and asking for cooperation. Finally, under contract with UAMS Dept. of Ped's and ACH, in the past year Child and Infant Death Review teams have been established in 3 sites covering 7 counties. //2013//

CSHCN Commissions, partnerships, advocacy groups: Located within the Arkansas Department of Human Services in the Division of Developmental Disabilities Services, the Title V CSHCN program works closely with providing early referral to children and youth for programs within the Division that will provide services throughout their lifetime. This includes the Alternative Community Services Waiver (commonly known as the DDS Waiver) which will provide services within the family home and in alternative environments such as alternate family placements. Title V CSHCN staff also provide information and assistance in obtaining services for youth that are aging out of our program through independent living situations such as group homes and apartments. The Title V CSHCN staff also works with other Divisions within DHS to obtain services for CYSHCN. Referrals for enrollment with a Medicaid Primary Care Physician are completed with assistance from the Division of County Operations as well as referral for Medicaid applications. Our staff is able to access the data system within that Division, ANSWER, and subsequently follow the progress of the applications. The Title V CSHCN program is also an active participant in the Assuring Better Child Development (ABCD) III project coordinated between the Division of Medical Services and the Division of Child Care and Early Childhood Education. In addition, Title V CSHCN personnel are active in the Arkansas Early Childhood Care and Services (AECCS) program as members of the Partnership Council. CSHCN staff members have served on committees on Medical Home with Medicaid and also with AECCS to expand the understanding and utilization of the standards of the Medical Home in program development. Statewide Title V CSHCN staff members are active participants in the local

Hometown Health Initiative teams within the Arkansas Department of Health. Title V CSHCN personnel also participate on the Oral Health Coalition, a group of programs and agencies, public and private, that have the common goal of increased provision of oral health services to all Arkansans. The Office of Oral Health in the Arkansas Department of Health is the driving force behind the coalition.
/2012/ The ABCDIII initiative, AR LINKS (Linkages Improve Networks and Knowledge of Services) pilot projects have begun with active involvement of Title V CSHCN staff on the Core team and community teams. AR LINKS will continue to promote the use of Ages and Stages Questionaire (ASQ) and will expand the work to include coordination and linkages of services at the community level. AR LINKS will work with five pilot communities (Forrest City, Jonesboro, Clinton, Benton, and El Dorado) to conduct local "learning collaboratives," gather feedback and input on linkages at the community level and recommendations for improvement, collect data from PCP "champions" and other providers in the community regarding developmental screening and follow up, and develop a statewide spread strategy. In addition, the Arkansas Medicaid will provide technical assistance to PCPs in the five communities through the AR Foundation for Medical Care (AFMC). Implementation of community pilots began in March 2011.
The Team Up Autism Conference 2011 focused on evidence based interventions for children with Autism. The program was a joint collaboration between the University of Arkansas College of Medicine Developmental-Behavioral and Rehabilitative Pediatrics, James L. Dennis Developmental Center, Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program at Partners for Inclusive Communities and a HRSA grant award. Title V CSHCN program management served on an oversight team and provided training to approximately 400 attendees. Title V CSHCN caseworkers and management staff were supported in their attendance in part with funding from the LEND program.
The Community-Based Autism Liaison and Treatment (CoBALT) Project has begun with recent training of the first three local teams each consisting of a Physician and a therapist (preferably a Speech-Language Pathologist). Developed by Dr. Eldon Schulz, Rockefeller Chair, UAMS Department of Developmental Pediatrics, the program emphasizes earlier identification of Autistic Spectrum Disorders and earlier referrals into appropriate services. Building on the University of Arkansas for Medical Sciences (UAMS) missions of teaching and training and in collaboration with multiple other agencies, the CoBalt project will train and provide ongoing telehealth consultation to physicians and other pediatric providers to triage children with suspected ASD into appropriate and high quality services. When available, electronic medical records (EMR) will be used to facilitate communication. The expectation is that this clinical-professional service can be billed to the child's insurer. The Title V CSHCN program is represented on the CoBALT oversight team and provides training to new teams. CSHCN staff attend the training to enhance the development of the local teams. The Title V CSHCN program will provide financial support for training costs in the future. //2012//
/2013/The funding of the CoBalt project ended. Title V CSHCN program provided funding to enable on-site review of the initial sites to assure fidelity to the project. Research will soon begin for possibility of funding through an established intra-agency contract. Title V CSHCN staff work actively on the Pediatric Genetics Committee. This year the target area for this committee is to begin a Folic Acid campaign. Dr. David Grimes, MCH Director, is a leader in this committee's work. Chair of the committee is Dr. Bradley Schaefer, Director of the Division of Medical Genetics at UAMS. //2013//
The state's only medical school, the University of Arkansas for Medical Sciences (UAMS), offers many broad contributions to health care within the state. ADH has a multi-faceted relationship with UAMS, with both formal and informal partnerships at many levels. Perhaps the most significant example relevant to MCH is that Dr. Nugent served his entire tenure as MCH Director at ADH via contract with the UAMS Department of OB/GYN. Other specific examples of formal agreements include a contract with the UAMS Department of Pediatrics to provide subspecialty consultation to ADH in follow-up to abnormal newborn screening results, including housing a newborn screening coordinator within the Genetics Section; a memorandum of agreement with UAMS Partners for Inclusive Communities (PIC) to promote sickle hemoglobin trait counseling services offered through PIC; a technical services agreement with UAMS College of Allied Health Professions to provide audiological diagnostic services in follow-up to newborn screening in six

sites; and a contract with the Department of OB/GYN to provide prenatal care for high-risk patients referred from local health units.

Also under the auspices of UAMS is the College of Public Health (COPH), which was established in 2002. The COPH includes the shared missions of 1) meeting the public health workforce needs for the future and 2) demonstrating how public health approaches can address the health needs of Arkansans via model community programs. Pilot sites for teaching and learning also serve as innovative laboratories for new and creative approaches to old problems. Degrees currently offered include the MPH, the DrPH (Public Health Leadership), and two PhD's (Health Policy and Management, and Health Promotion and Education). The COPH is accredited by the Council for Education in Public Health. Many ADH leaders are active as adjunct faculty and are involved both in teaching and research through the College.

Also connected to UAMS is the Arkansas Center for Health Improvement (ACHI), whose mission is to provide relevant research on needs in Arkansas and on relevant public health practices, and to facilitate translation to action. ACHI is staffed by UAMS faculty and other employees, and is under the direction of Dr. Joe Thompson, who also serves as Arkansas's Surgeon General. One example of ACHI activities is the collection, analysis, and reporting of BMI data collected from school children as a result of Arkansas Act 1220. In general, ACHI serves as a resource center and think tank which provides valuable recommendations to the Arkansas Board of Health and other public health entities in the state.

A final UAMS initiative of special significance to MCH is the ANGELS (Antenatal and Neonatal Guidelines for Education and Learning System) project, which has received generous support via federal Medicaid dollars (Center for Medicare and Medicaid Services). ANGELS has attempted to promote development of a more regionalized system of perinatal care in the state to assure that care for high-risk pregnancies and deliveries takes place in appropriate centers. The project has also developed a large number of specific practice guidelines for use by prenatal and neonatal care providers. Telemedicine networks for both obstetric and neonatal providers have been established, with routine videoconferences now conducted. Support for local providers through remote consultation featuring such services as real-time interpretation of fetal ultrasounds has also been provided. Dr. Nugent was heavily involved in the program's research efforts as a member of the Core Evaluation Team, and it is anticipated that his successor will be similarly involved. Several scientific papers related to ANGELS have either been published or are in process at this time.

/2012/ A new pilot study was started in January 2011 with ANGELS program and the Miller County Local Health Unit (LHU) to provide maternity patients phone consultation with high risk OB nurses (and MFM consultation if necessary) on nights, weekends, and holidays when the LHU is closed. This is planned for patient support and reduction of unnecessary Emergency Department (ED) visits. This will be expanded regionally and then statewide. This service is available at no costs to any patient through a Medicaid grant. Five LHU sites are currently doing Tele-Video High Risk OB Consults (all LHU statewide currently have phone MFM consult capabilities) with plans for expansion to all maternity sites state wide. Tele-Video colposcopy (for patients with abnormal Pap smears) with UAMS is also being piloted at no cost to patients with plans for regional and state wide expansion. LHU serve as Arkansas' final safety net serving as a provider of prenatal and family planning care when local resources are unavailable or unwilling to provide care to these patients. //2012//

3. State-local health agency relationships

The Arkansas Department of Health is a highly centralized structure. Unlike some states, local health departments have limited autonomy in Arkansas. Local health unit (LHU) activities are largely managed through the Center for Local Public Health, which has five regional offices that provide more direct day-to-day guidance for LHU operations. Clinical activities with programmatic management based within the Center for Health Advancement and Center for Health Protection

(WIC, Maternity, Immunizations, etc.) are conducted in LHU's. Because of this, there is a need for internal coordination with Local Public Health. Center leaders meet regularly at Senior Staff meetings and also informally as needed. Two other forums also exist to help Centers collaborate. The Scientific Advisory Committee develops and assures the use of the public health evidence base to support the assessment, policy and assurance functions of the ADH. Also, the Doctors' Horizontal Team provides links among agency medical professionals including physicians, dentists, veterinarians and other doctoral-level personnel.

Hometown Health Improvement (HHI) is a process designed to empower local communities to identify and focus on issues of local importance. Although supported by the Arkansas Health Department, HHI is considered to be locally owned and locally controlled. HHI coalitions exist in every county of the state, although some are more active than others. Typically, the local health unit administrator is a driving force in sustaining a community coalition, but in some cases already-existing local initiatives have been brought under the HHI umbrella. HHI has state-level coordination that supports local groups through data collection and interpretation, assistance with coalition-building, dissemination of information, training, and evaluation. Examples of activities undertaken by local coalitions include tobacco cessation for adolescents, household hazardous waste removal, local industry wellness, health fairs, parenting support groups, and health resource guides. Community members have participated in training sessions on community assessment, coalition-building, and effective partnership-building.

Other examples of state-local partnerships are the Unwed Births Prevention program and the Abstinence Education Program. In each of these initiatives, community organizations applied for subgrants from ADH under a request-for-applications process. Last year funds were awarded to four county coalitions for Unwed Births and to six community-based organizations for Abstinence Education. Although these projects have since been discontinued due to lack of funding, a similar model may be applied in future years as new funds emerge for teen pregnancy prevention. One other major state-local partnership started in late 2009 is the STAR Health initiative. This effort attempts to marshal additional health, economic, and educational resources to combat health problems in three southeast Arkansas counties: Chicot, Desha, and Lincoln. A steering committee composed of state and local community representatives meets regularly. Nine lay community health workers have been hired to provide outreach to vulnerable individuals, and Americorp volunteers have been enlisted to provide community-level awareness. Community providers from private and public sectors have become engaged, and funding support from a variety of sources (state and private foundations) has been received. Goals of STAR Health include reduction of infant mortality, teen pregnancy, and chronic disease; improved education outcomes; and sustained economic development for the three counties.

/2012/ The STAR Health project has progressed over the past year. Community health workers (CHWs) have moved from "extra help" positions to regular ADH salaried positions; there are now 4.5 FTE CHW positions. Activities have been multiple and varied, including assistance in obtaining local health and social services; prescription drug assistance; and health promotion activities including Walk at Lunch events, healthy heart luncheons, baby showers for groups of pregnant women (at which health and safety topics are discussed), health fairs, and outreach to churches to educate around such issues as hypertension, heart disease, tobacco, and strokes. STAR Health has also succeeded in getting three school districts added into the Coordinated School Health initiative. //2012//

/2013/ STAR Health continues with the same activities as above, but procurement of sustained funding remains a challenge. In the past year a conscious effort has been made to more thoroughly engage local leaders in the project and permit more local input into program priorities. //2013//

4. Local human service agency interactions

As a result of Hometown Health Improvement, a number of robust partnerships have been

formed in many communities across Arkansas. HHI coalitions typically include representation from local public health, community health centers (if present), hospitals, county government, private medical providers, public schools, business interests, non-profits, county DHS office, and other interested parties. As described above, these coalitions have gathered local data, chosen priorities, and implemented local strategies to tackle health problems.

Local coordination also occurs in response to public health exigencies. One example is influenza vaccination for school-age children. When the Governor placed a line item in the SFY2010 budget calling for flu vaccination to be offered to every child in the state in the fall of 2009, local health units partnered with local schools to ensure a seamless delivery of service to school children. Having this planning process in place greatly facilitated delivery of additional vaccines for the new H1N1 flu strain that year.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicators (HSCI's) primarily assess, in a general fashion, how well state programs such as Medicaid, SCHIP, and CSHCN are meeting the needs of those eligible for such services. They also assess Title V programs' ability to access relevant data sources and linkages. While CSHCN data are quite accessible to the Arkansas program, Medicaid data require a formal request through the Medicaid agency (housed in the Arkansas Department of Human Services). The following commentary addresses selected HSCI's of particular interest to the Arkansas MCH team.

Rates of infant participation in EPSDT (HSCI #02) have been somewhat variable in past years due to presumed differences in calculation methodology by the state Medicaid data unit, but results from the past 2-3 years are thought to reflect consistent methods. It remains troubling that more than one-fourth of eligible Medicaid infants are not receiving even one EPSDT screen. However, Medicaid is likely to be counting all infants who enrolled during the year, including those who enrolled in the last month of the year and therefore may not have had time to have their first visit. EPSDT provision within the context of a true medical home remains a priority for the state Medicaid program. Ongoing conversations between ADH and state Medicaid officials reveal that Medicaid is satisfied with continuing progress in this area for infants and older children alike. A major barrier to rapid improvement is the continued shortage of primary care physicians in the state, particularly in rural locations. Attention to preventive care is often relegated to a lower priority when physicians have a heavy burden of acute care to provide.

Completeness of prenatal care (HSCI #4) is a key indicator for the ADH Maternity Program. Infants born to mothers who receive no prenatal care have five times the infant mortality risk compared to those whose mothers receive adequate prenatal care. The percentage of women with adequate care as judged by the Kotelchuck Index has been stable in Arkansas at around 81% for the past five years. ADH continues to provide maternity services in 61 Local Health Units in 55 of Arkansas' 75 counties. Women seeking prenatal care, regardless of insurance coverage or income level, can access maternity services at these sites. Local health units average 5,100 initial prenatal visits annually. ADH continues to assist patients in getting presumptive eligibility Medicaid and provides care at least until patients are approved for Medicaid. ADH then locates a prenatal provider for the patient depending on available community resources. If no provider is identified or the mother is ineligible for Medicaid, ADH continues service provision for the remainder of the pregnancy.

ADH has also maintained a contractual agreement with the Arkansas Department of Human Services to manage ConnectCare which connects Medicaid and ARKids recipients to a primary care physician and a medical home. The ConnectCare Section provides the Happy Birthday Baby Book upon request to pregnant women which provides prenatal information along with coupons and discounts for keeping doctor appointments. The Family Health Branch and In-Home Services Branch have jointly initiated (in seven Delta counties) the Nurse-Family Partnership home visiting program, which strongly encourages participants to obtain regular prenatal care.

In-Home Services additionally continues to operate the Maternal-Infant Program, another home visiting program targeting younger mothers, in virtually every county in the state.

Comparison of key protective factors and birth outcomes between Medicaid and non-Medicaid populations (HSCI #05) is very telling. For all of these measures (05a -05d), the Medicaid population continues to have worse results. Percentage of low birth weight babies and infant mortality are especially disparate between the two groups. Since Medicaid births now account for about 65% of all deliveries in Arkansas, they are the driving force behind overall rates. Improving rates of early and adequate prenatal care for Medicaid beneficiaries would surely contribute to improvements in LBW and infant death rates but are not the only answer. Other socio-economic inequities that correlate closely with Medicaid eligibility must be adequately addressed before parity in health outcomes can be achieved. In the meantime, ADH continues to offer maternity clinic services as above. About 75% of women seen for ADH prenatal services are eligible for or receive Medicaid. However, only about 57% of women seen for maternity care at ADH in 2011 had their first visit during their first trimester; this statistic alone reflects the higher risk of the population served through ADH. For the many thousands of Medicaid beneficiaries not seen through ADH, more needs to be done to encourage early prenatal care. The ConnectCare Program administered through the Health Connections Branch is doing its best to inform beneficiaries through newsletters, Happy Birthday Baby Books, telephone calls, and face-to-face contacts at various events about the importance of early and regular prenatal visits. ConnectCare is also the typical route through which pregnant Medicaid recipients are assigned a prenatal physician.

Another indicator of interest to the MCH Program is the proportion of Medicaid children who have received a service through the program (HSCI #07A). Arkansas Medicaid can only provide accurate counts for actual Medicaid beneficiaries, not those "potentially eligible." It is not surprising that almost all Medicaid-enrolled children had at least one service paid for through the program last year and in prior years as well. Again, the ConnectCare Program deserves credit for promptly linking children enrolled in Medicaid with primary care providers.

Another gratifying statistic is the percentage of Medicaid children 6-9 years old who received dental services last year (HSCI #07B). For the third year in a row, this indicator improved, again a testament to the work provided by ConnectCare in linking beneficiaries with family dentists. The improvement seen is especially significant given the shortage and maldistribution of primary care dentists in the state.

The ability of the state to assure Maternal and Child Health (MCH) program access to policy and program relevant information (HSCI #09A) has not changed since last year. ADH still has direct access to electronic databases for the following linked data: birth/infant death certificates; birth/ Medicaid claims files; birth/WIC; birth/newborn screening files as well as the following registries and surveys: Hospital Discharge Data System and PRAMS. All of these linked data sets and surveys are very important to program planning efforts. ADH does not have direct access to an electronic database of the birth defects surveillance system. Those data are located at the Arkansas Center for Birth Defects Research and Prevention, a part of UAMS, but selected statistics can be obtained upon request.

Additionally, the situation has not changed for HSCI #09B regarding access to data on adolescent tobacco use. ADH does not have full and direct access to Youth Risk Behavior Survey (YRBS) data; the Arkansas Department of Education (ADE) collects, analyzes, and maintains raw data from the YRBS and produces a comprehensive report of survey findings. Detailed state-specific YRBS data are also readily accessible on the CDC website. ADH does have access to the Youth Tobacco Survey conducted jointly by ADH and ADE.

The Title V CSHCN program provided case management services to approximately 6,978 children and youth with SSI coverage in the state of Arkansas. This number represents a slight drop from previous years that can be attributed to further data clean-up conducted throughout the

past year. In addition to case management services, the Title V CSHCN program has provided assistance by purchasing equipment not covered by Medicaid, paying for attendance at summer medical camps and limited assistance with respite funding.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The process to determine priority needs for pregnant women and infants, children, and (non-pregnant) women began with a thorough review of data relevant to health issues of these groups. An MCH Needs Assessment Planning Team was established which consisted of leaders from the Perinatal Health and Reproductive Health Programs within Women's Health, the Child and Adolescent Health Section, and the Office of Oral Health. In the spring of 2009, the Team organized a group of external stakeholders representing all three sub-interests that included community, academic, and state agency participants. After relevant data were presented to the three sub-groups, a master list of potential priorities was then generated and narrowed further using a group process.

Priorities for Children with Special Health Care Needs were established using a separate process. The CSHCN Program partnered with the LEND (Leadership Education in Neurodevelopmental and related Disabilities) program at UAMS to help coordinate needs assessment activities. Surveys were mailed to 2,500 families served by the CSHCN Program in early 2010. In addition, a total of 11 community forums were held in cities and towns around the state during 2009-10. Attendees at these forums were allowed to participate in a "voting" process to identify issues of greatest import. Additionally, a focus group was organized to solicit input from local and regional CSHCN staff.

Through these processes, various Stakeholders suggested the following set of priority issues for pregnant women and infants, children, and non-pregnant women:
1. Increased EPSDT screening rates
2. Access to the medical home
3. Care coordination for children, including use of human service workers in schools
4. Increased provision of dental screening, sealants, and water system fluoridation
5. Enhanced parent health literacy
6. Creation of school-based wellness centers
7. Childhood injury prevention
8. Prevention of teen pregnancy
9. Lifestyle/behavioral changes to improve pregnancy outcomes (alcohol use, smoking, oral health, etc.)
10. Access to prenatal/intrapartum care
11. Services for infants (e.g. immunizations, well-baby)
12. Chronic disease self-management for women
13. Reduction of Chlamydia infection rates
14. Health disparity reduction (non-traditional approaches)

The CSHCN Stakeholder groups recommended the following potential priorities:
1. Increased communication regarding available CSHCN programs and services
2. Improved access to a trained and knowledgeable Title V CSHCN workforce
3. Development of a more accessible diagnostic infrastructure within the state to assure early diagnosis and treatment of developmental disabilities
4. Other - DDS Waiver issues, education and school problems, availability of training, transportation difficulties, respite care (or lack thereof)

During the year following the 2009 MCH stakeholder meetings, other potential priorities also emerged through ongoing partnership activities. These included: 1) enhanced training for first responders in the CDC's Sudden and Unexpected Infant Death Investigation (SUIDI) process; 2) establishment of an infant death review process; 3) reduction of smoking among women of childbearing age; 4) tobacco use among adolescents (as measured through Coordinated School health activities); 5) improved developmental and social-emotional screening of young children; and 6) enhanced screening of post-partum women for depression (possibly to be conducted as a

Region VI joint priority).

The MCH NA Planning Team carefully considered these suggested priorities throughout the duration of the Needs Assessment process. Clearly, many of the areas suggested are already addressed through national performance measures, health status indicators, and health system capacity indicators. The Planning Team factored in analysis of many data elements from the needs assessment as well as ongoing state efforts and capacity in arriving at the following final list of state priorities for the coming five years:

-Reduce births to older teens
-Reduce smoking among women of childbearing age
-Improve trauma care for children
-Improve oral health in children and women
-Reduce obesity and overweight among school-aged children
-Improve communication between the Title V CSHCN program and the CSHCN population
-Improve training and program development for the Title V CSHCN workforce

These priorities and accompanying state performance measures are discussed further in the next section.

B. State Priorities

Each of the selected state priorities will be discussed in detail.

1. Priority: Reduce births to older teens

SPM 1: The rate of birth (per 1,000) for teenagers aged 18 through 19 years

This priority links to NPM 8, births to teens 15-17 years old. Arkansas has traditionally had higher rates of births to teens, although actual pregnancy rates among teens are similar to the national average. Part of the rationale for the selected priority and SPM is that Arkansas has the highest rate of births to 18-19 year olds, according to rankings released by the Guttmacher Institute in 2010. Although they are older adolescents, most 18 and 19 year olds are not financially, developmentally, or emotionally prepared to be parents. Many interventions effective for younger teens will impact 18 and 19 year olds as well. Finally, only 38% of Arkansas youth who start college actually graduate, and unintended pregnancy during the first years of college may well be an important contributor.

Arkansas has numerous resources at hand to continue to combat births to teens. ADH is the largest public provider of family planning services in the state, with confidential services available to both female and male youth in every county. Community Health Centers, AHEC's, Planned Parenthood, and other private providers (e.g. physicians' offices) also provide a fair share of services. Although Unwed Births Initiative and Abstinence Education activities were suspended in mid-2009, substantial new federal teen pregnancy prevention funds have recently been announced, and the state intends to actively pursue those. Re-authorization of abstinence-only education funds also affords a potential avenue to pursue. The recent establishment of school wellness centers linked to the Coordinated School Health process creates additional venues for teen pregnancy prevention activities, even if direct family planning services are not provided on campus.

Other opportunities for intervention related to this measure include increased outreach to colleges and universities within the state. Currently ADH operates satellite family planning clinics at two colleges. In addition, more local health units could be encouraged to offer family planning services at alternative hours (nights, weekends) targeted specifically to teens, as is currently

done in three counties. Finally, and perhaps most importantly, the Medicaid Family Planning Waiver could be better publicized to encourage more young women to take advantage of covered services.

2. Priority: Reduce smoking among women of reproductive age

SPM 2: The percentage of women aged 18-44 years who report being current smokers

Smoking has many well-documented adverse consequences throughout the reproductive years and beyond. In addition to increasing risk for many types of cancer and for chronic lung disease, smoking is a major risk factor for cardiovascular disease. Smoking during pregnancy is associated with lower birth weights, major obstetrical complications, and higher risk of SIDS. The detrimental effects of secondhand smoke on children are also myriad. According to an analysis published in MMWR in December 2009, compared to other states Arkansas had the eighth highest rate of smoking-attributable mortality among females during 2000-2004. The female smoking-related mortality also increased in Arkansas when compared to 1996-1999.

This priority is related to NPM 15, women who smoke during the last 3 months of pregnancy, but is much broader in scope. Data on smoking trends among Arkansas women are available through the Behavioral Risk Factor Surveillance System. This telephone survey is conducted annually and is scientifically weighted to reflect the state as a whole.

Resources to combat smoking among Arkansas women are very robust. The ADH Tobacco Prevention and Cessation Program (TPCP) supports the statewide Stamp Out Smoking initiative aimed at both primary prevention and cessation of smoking. Many anti-tobacco programs and curricula are based in schools, particularly Coordinated School Health Schools that receive TPCP funds. An ongoing media campaign involves ads on TV, radio, and in print media. TPCP sponsors the Arkansas Tobacco QuitLine, a toll-free telephone helpline for free tobacco cessation counseling, nicotine cessation medication (depending on availability), and information on state and local resources to help Arkansans stop using tobacco. The Arkansas Tobacco Quitline provides a special tobacco cessation program with extended services designed for pregnant and postpartum women.

Within ADH Women's Health programs there exists additional capacity to discourage smoking. While Women's Health Nurse Practitioners are very well-informed and engaged in promoting smoking cessation in maternity and family planning clinics, public health nurses (PHN's) are typically less so. An opportunity exists to train more PHN's in smoking cessation and to institute policy changes that would make cessation-related referrals and follow-up by PHN's more routine.

3. Priority: Improve childhood trauma care

SPM 3: The proportion of children aged 0-21 with injury severity score of >15 who receive definitive treatment at either a Level I or Level II trauma hospital

This priority ties to NPM 10, deaths to children 0-14 due to motor vehicle crashes. Unintentional childhood injury death rates in Arkansas have traditionally greatly exceeded national rates, often by 50% or more. In addition to motor vehicle crashes, causative events for which the state suffers excess childhood mortality include house fires, drowning, and unintentional firearm injuries. Lack of public awareness and the rural nature of much of the state have often been blamed for these deaths. Many have also pointed to historic lack of a statewide trauma system as being an important factor.

An exciting recent development is the appropriation of almost $20 million in state funds toward creation of a statewide trauma system. Many committees and subcommittees consisting of a multitude of internal and external stakeholders have been working the past year to lay out the structure of the new system and determine needed resources to make it work. A new Trauma

Section has been established within the ADH Injury Prevention and Control Branch to oversee the system, and a director to head up the new section was recently hired. When fully operational, the trauma system should improve transport times and allow for assignment to the most appropriate trauma care facility based on the nature of the injury. The Injury Severity Score is calculated using the Abbreviated Injury Scale (AIS) assigned in the field and is a useful indicator of the severity of injury. The AIS is utilized for most children with more severe injuries and is information that will be collected through the state Trauma Registry housed within the Arkansas Department of Health. As the trauma system unfolds, more children with severe injuries should be appropriately triaged and dispatched to higher level care facilities. Therefore, the above state performance measure should serve as a reasonable indicator for how trauma system development is progressing with respect to childhood injuries.

4. Priority: Improve oral health in children and women

SPM 4: The percentage of people on community water systems whose water is appropriately fluoridated

This priority is related to NPM 9, percent third grade children with dental sealants. Oral health in Arkansas has been a continuing challenge for many years due to lack of and maldistribution of providers and a relative lack of fluoridated water supplies. Children in the state suffer more dental decay than in many states, and women also feel the effects of cavities and periodontal disease. Although the issue goes well beyond water fluoridation, progress in that arena should serve as a correlate for improved dental health overall.

Data for the new state performance measure will be obtained from the ADH Office of Oral Health (OOH), which has been very involved in promoting fluoridation of public water supplies. As a partner to OOH, the Arkansas Delta Dental Foundation has contributed many thousands of dollars to fund needed equipment and supplies for community water systems that elect to fluoridate, and now 65% of Arkansans on such systems receive water with recommended levels of fluoride. Legislation to mandate fluoridation of all public water systems has been drafted and introduced several times but to date has not passed. In the meantime, OOH has worked with individual systems to raise awareness and support for fluoridation, adding a number to the ranks of the voluntarily "fluoridated" over the past ten years. OOH has also partnered with a number of groups to provide and promote dental sealants in children.

5. Priority: Reduce obesity and overweight among school-aged children

SPM 5: The percentage of school-age children with body mass index >85th percentile

This priority represents a continuation of childhood obesity as an area of focus. However, the previous two state performance measures have been combined into a single measure. This measure is related to NPM 14, WIC children aged 2-5 years with BMI >85th percentile. Obviously, however, the targeted age range for this state measure is older than that for NPM 14. Arkansas is blessed to have available a large amount of BMI data from school-aged children, thanks to a requirement of Arkansas Act 1220 of 2003. The same act established the Child Health Advisory Committee, which is charged with recommending policies for schools in the state that will lead to reduction of child obesity. Many other interests in the state, such as the Arkansas Coalition for Obesity Prevention, also have a stake in seeing this problem improve. While rates of overweight/obesity among children have not declined significantly the past six years, they have leveled off and evidence of decline is expected shortly. Given the intense ongoing activity in this arena, continued focus is clearly warranted.

The other former state measure for obesity in children (% WIC children with wt/ht >95th percentile) has been dropped due to its close similarity to NPM 14.

6. Priority: Improve communication between the Title V CSHCN program and the CSHCN

population

SPM 6: The percentage of respondents indicating Title V CSHCN program personnel have communicated information on one or more program(s) or service(s) that was helpful in meeting a family or individual need within the previous year.

This priority ties to all five of the CSHCN NPM's. Data will be obtained from an annual survey with questions targeting the measure. Assistance from Departmental and other experts on survey development will be required. This measure should show an increase in subsequent years. Families indicated during focus groups and on the survey that they have a tremendous need for information. Members of the focus groups were dissatisfied that information on programs and services was not readily available to them in this age of instant access. Resources to improve communication with the families of CSHCN include the development of the program's website and improved quarterly newsletters.

7. Priority: Improve training and program development for the Title V CSHCN workforce

SPM 7: The percentage of CSHCN care coordination staff expressing unmet needs related to workforce development and/or training

This priority ties to CSHCN NPM's 4, 5 and 6. Data will be obtained from an annual survey of CSHCN staff with questions targeting the measure. Assistance from Departmental and other experts on survey development will be required. This measure should show a decreasing percentage over subsequent years. The Employee Focus Group expressed disappointment in the training resources available to them as they strive to serve the CSHCN community. In addition, new programs developed within short time constraints proved problematic and made it especially difficult for care coordination staff to manage and provide adequate and correct information to the CSHCN community. Workforce development and empowerment are an essential element to the quality of services provided to the CSHCN community. By improving the training and tools available to the CSHCN care coordination staff, the services provided to the CSHCN community will improve as well.

/2012/ Priorities remain unchanged since formulated last year. However, ongoing work on the state trauma system has necessitated a minor change in State Performance Measure #3. During the past year, the decision has been made by the Governor's Trauma Advisory Council that children less than about 15 years old who have suffered moderate to severe trauma should all be transported to Arkansas Children's Hospital, the only Level 1 trauma center for children in the state. Older teens with injury severity scores of >15 might in some cases be appropriately transported to other facilities that serve both adults and children, but for younger children that would no longer be appropriate. Therefore, in order to capture the desired outcome, this measure has been modified to read as follows:
"The proportion of children aged 0-14 with injury severity score of >15 who receive definitive treatment at a Level I pediatric trauma hospital."

Discussions continue regarding the possibility of an additional priority and performance measure that would be common to all Region VI states. Given recent discussions among Region VI and Region IV State Health Officers, it is likely that such a measure would be related to infant mortality reduction. //2012//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	98.6	100.0
Numerator	33	47	60	69	64
Denominator	33	47	60	70	64
Data Source		Newborn Screening Program	Newborn Screening Program	Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2010
One (1) baby (Sickle Cell Disease) moved out-of-state and was unable to locate for follow-up.

a. Last Year's Accomplishments
The Newborn Screening self evaluation tool, PEAS (Program Evaluation and Assessment Scheme), was completed and provided the framework for the program strategic plan, including education and emergency plans. Follow-up protocols were reviewed and updated by nursing and medical staff. The Newborn Screening Nurse Educator continued to make annual site visits to the 41 birthing hospitals across the state for technical assistance, training, and collaboration. Specimen rejection rates have dropped significantly since hiring a Nurse Educator in 2008; from 1.2% of samples rejected in 2007 to 0.1% in 2011. Birthing hospitals were notified about availability of the Department of Health courier service to enable faster specimen delivery to the Public Health Laboratory and the program is following delivery time data. The program also collected baseline data for turn-around times for collection of secondary (repeat or confirmatory) specimens, and will be following turn-around times after parent and provider education is implemented.

The Arkansas Genetic Health Committee met quarterly during the past year. The Newborn Screening Subcommittee of the Arkansas Genetic Health Committee also met quarterly with discussions about additional future test inclusion, i.e. Severe Combined Immunodeficiency (SCID) and Critical Congenital Heart Disease (CCHD), and ideas for improvement in newborn screening protocols/practices.

Updates of parent resources were accomplished through revisions to the Newborn Screening website. New links were added and the site was made more user-friendly and culturally relevant. A new parent brochure was designed through a participatory process with stakeholders. The content reflects current national recommendations for newborn screening information for parents. The brochure will be disseminated to birthing hospitals, local health units, and maternal-child

home visiting programs.

The University of Arkansas Medical Sciences (UAMS) Partners for Inclusive Communities provided brochures to the Newborn Screening Program for inclusion in trait letters sent to parents. The brochures described the free counseling service offered by Partners for Inclusive Communities to parents of babies with sickle cell traits. These were sent to all families with a baby diagnosed with a sickle cell trait.

Children diagnosed with a condition identified through newborn screening continued to be followed annually until 5 years of age to determine health and developmental outcomes.

Through a grant from the state Medicaid office, Dr. Brad Schaefer and other staff within the University of Arkansas for Medical Sciences Department of Pediatrics continued work on a database for long-term follow-up of cases detected through newborn screening. This project will include long-term case data never collected before in Arkansas, nor in virtually any other state. ADH will collaborate with the project through requesting consent from parents of known cases to release ADH records (newborn screening, birth certificate data, immunization records) for use in project activities. Plans are to follow children with NBS-detected disorders up to 21 years of age.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Newborn Screening Subcommittee continued to hold quarterly meetings with goals of improving newborn screening system quality and planning for addition of new disorders.				X
2. Newborn screening follow-up protocols were reviewed and revised as needed to ensure all infants with positive results were tracked to diagnosis.				X
3. Visits were made by the Newborn Screening Nurse educator to every birthing hospital in the state to provide training and technical assistance in specimen collection.		X		
4. A performance management and improvement self assessment (PEAS) served as the continuous process for improvement and strategic planning and was fully implemented last year.				X
5. Collaboration continued with the ACH/UAMS NBS Coordinator to coordinate follow-up care of infants with abnormal screening results.		X		
6. Collaboration continued with UAMS Department of Pediatrics on a Long-Term Follow-up database designed to track known cases diagnosed through newborn screening.				X
7.				
8.				
9.				
10.				

b. Current Activities

Annual site visits to birthing hospitals and newborn screening training specific to specimen rejection and correction of problems (i.e. mailing specimens, entry of demographics, specimen information, and prompt specimen delivery to the lab) are ongoing and remain a high priority of the newborn screening program.

The Arkansas Genetic Health Committee continues to meet quarterly. The Newborn Screening

sub-committee also maintains a quarterly meeting to discuss current ideas and solutions pertinent newborn screening in the state such as quality improvement and planning for new disorders such as CCHD and SCID.

The program is working closely with the Arkansas Children's Hospital collaborative on statewide infrastructure development for CCHD screening.

The Newborn Screening Program nurses at the Arkansas Department of Health continue to work daily with the Newborn Screening Coordinator at Arkansas Children's Hospital to coordinate follow-up care for babies with abnormal newborn screening results including those who require second tier testing.

c. Plan for the Coming Year

The Newborn Screening Program will continue to make quality assurance a priority through improvements on accuracy and promptness of specimen submission, analysis, and follow-up. The program was recently awarded a small ADH grant to assess outreach, technical assistance, and training needs of hospital nursery personnel in order to improve outreach and education. The intermediate-term aim of the project is to improve specimen collection techniques (decrease rejections), decrease written errors on the blood spot form, and improve delivery times to the public health lab.

The program will continue to work with the University of Arkansas Medical Sciences, Department of Pediatrics, as they develop a secure database for long term follow-up of confirmed cases. The database will follow confirmed disorders diagnosed through the newborn screening process over an age range of 0-21 years of age.

The newly designed newborn screening parent brochures will be disseminated to all birthing hospitals and will be available to local health units and maternal-child home visitation programs.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**37580**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	37016	98.5	39	5	5	100.0
Congenital Hypothyroidism (Classical)	37016	98.5	722	18	18	100.0

Galactosemia (Classical)	37016	98.5	11	2	2	100.0
Sickle Cell Disease	37016	98.5	21	21	21	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	57	62	63	64	65
Annual Indicator	61.7	61.7	61.7	61.7	69.5
Numerator	468	468	468	468	537
Denominator	759	759	759	759	773
Data Source		Data from Nat'l CSHCN Survey, 2005-2006	Data from Nat'l CSHCN Survey, 2005-2006	Data from Nat'l CSHCN Survey, 2005-2006	Data from Nat'l Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	70	71	72	73	74

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data is from the National Survey of CSHCN conducted in 2005 - 2006.
A statewide survey was mailed to parents/guardians of CSHCN in early 2010. 93.7% of the respondents indicated they are often or always included in their child's health care decisions. 66.1% indicated their child's health care team often or always listened to their concerns or questions. The same percentage indicated that the health care team asks that the parent/guardian share with them their knowledge and expertise as the parent/caregiver. However, only 32.1$ indicated that they were asked by the health care team how the child's condition affects the family (e.g. the impact on siblings, the time the child's care takes, lost sleep, extra expenses, etc.).

a. Last Year's Accomplishments
Initiated grant with Family 2 Family Health Information Center in Arkansas. Initial grant funding from MCHB enabled the project to hire 5 regional coordinators to work 8 hours per week in their respective areas. The grant from Title V CSHCN enables the regional coordinators to work 24 hours per week.

Contact information is provided to the F2F regional coordinators as a result of responses from families who complete a form giving permission to share their name with other parents of CSHCN in their area. F2F coordinators make contact with the parents and provide information and support as needed.

A grant was initiated with the Parent Advisory Council of the Title V CSHCN program which provides funding for the Project DOCC (Delivery of Chronic Care) program. Since Project DOCC began with training of Parent Advisory Council parents funding has moved between grants from various entities; none of them could be considered a permanent funding source. With the Title V CSHCN grant, the funding is more stable, enabling the program to grow.

The CSHCN program coordinated an Autism Family Support Grant utilizing state general revenue funds dedicated to an early intervention Autism Waiver currently in development. For a period of 3 months, grant applications were received on behalf of approximately 850 individuals diagnosed with an Autistic Spectrum Disorder. Eligibility for the grant was determined by CSHCN staff and processed for payment over a period of an additional 3 months.

Title V Family Support/Respite program has continued to provide assistance to families whose CSHCN meets eligibility criteria and who require assistance in the purchase of goods/services not covered by other sources.

The Division of Developmental Disabilities Services Special Needs program is coordinated by Title V CSHCN staff. Eligibility for the program is determined based on the need exhibited and diagnostic eligibility being met.

CSHCN program continued to fund weekend respite services for CSHCN whose parent is active duty military and stationed at Little Rock Air Force Base. Camp Aldersgate, a medical camp supported by the faith-based community, provides respite weekend services at a nominal fee, with slots reserved for use by these military families who are stationed away from the supportive environment of family and friends.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Title V CSHCN funds allowed 5 Family 2 Family Information Center regional coordinators to work 24 hours per week				X
2. Family to Family regional coordinators provided direct information and support to families		X		
3. The Delivery of Chronic Care program was carried out in conjunction with the CSHCN Parent Advisory Council				X
4. An Autism Family Support program was coordinated, involving processing of applications on behalf of 850 individuals with ASD		X		
5. The Family Support/Respite program continued to assist families with purchase of goods and services not covered through other sources		X		
6. Weekend respite services were provided to active duty military families		X		
7.				
8.				
9.				
10.				

b. Current Activities
The ARSIP grant began 07/01/11. The ARSIP Consortium is made up of representative state agencies, community groups & families. A Strategic Planning session was held 04/17/12 with a group of 57 persons including 10 parent/family representatives assisted in targeting areas for goals & objectives with this grant.

Parent Advisory Council (PAC) representatives meet quarterly in Little Rock for training, then return to their communities to pass information to other parents by e-mail, support meetings, and face-to-face sharing of information. During one quarter this past year, PAC members logged 523 volunteer hours & led or attended 22 in-person, Facebook & internet support groups, board meetings, fundraisers, & one-to-one advocacy situations.

The CSHCN program provided:
Sub-contract with the PAC to fund Project DOCC during the state fiscal year. A total of 32 Pediatric Resident Physicians were trained during 96 encounters between families & the Physicians.
Sub-contract with the Family 2 Family Health Information Center during the state fiscal year to enable parent employees increased work hours each week.
Funding in April 2012 to bring Mr. Don Meyer to Little Rock for a SibShop training. A multi-agency coalition worked to make the training a success.
Training to the Arkansas Governor's Developmental Disabilities Council's Family Leadership Project participants.
The Title V CSHCN Family Survey was developed with help from ARSIP staff to gather information to guide program services.

c. Plan for the Coming Year
The sub-contract between CSHCN program and the Parent Advisory Council for Project DOCC has been renewed and will continue at the same level of funding.

The sub-contract between CSHCN program and the Family 2 Family Health Information Center has been renewed and will continue at the same level of funding.

Continue support of the activities of the Parent Advisory Council.

Increase involvement and interaction between CSHCN staff, Parent Advisory Council staff and

Family 2 Family staff.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	68	68	54	53	55
Annual Indicator	50.2	50.2	50.2	50.2	46.6
Numerator	379	379	379	379	353
Denominator	755	755	755	755	758
Data Source		This data comes from the National Survey of CSHCN	This data comes from the National Survey of CSHCN	This data comes from the National Survey of CSHCN	Nat'l Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	51	52	53	54

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions

and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
This data comes from the National Survey of CSHCN 2005 - 2006.
In early 2010 a survey was mailed out to parents/guardians of CSHCN. The survey respondents answered the following questions on communication with the health care team. 71.4% answered often or always that the health care team uses helpful ways to communicate with me (e.g. explaining terms clearly, giving out forms to help us prepare for our visits). 48.2% answered often or always that the health care team uses helpful ways to communicate with my child. 70.5% answered that the health care team often or always understands the family's needs and values. 58% answered that they often or always have someone to help them understand all of the child's health services. 58.9% answered that they can often or always get the health care that my child needs when we need it, including after office hours, on weekends and holidays.

a. Last Year's Accomplishments
Title V CSHCN program is partnering with UAMS Department of Behavioral Pediatrics to implement the CoBalt Project. The project aim is to train and support community-based mini-teams to do Tier II evaluations for Autistic Spectrum Disorder. The trained team consists of a physician and a therapist whose evaluation will assist in determination of a diagnosis and immediate referral to services that include Part C Early Intervention and the Title V CSHCN program. Local program staff (EI and Title V CSHCN) attends the training session to assist in development of the referral tract within the community.

Title V CSHCN staff participate on the state level core team for the ABCD-III AR LINKS (linkages improve networks and knowledge of services) funded by Commonwealth Fund. The goal is to improve the process of sharing information between early intervention providers and the primary care physician in a more efficient and informative manner. The project has 5 pilot sites statewide and each site has community teams/partners that include physicians, Part C staff, Title V CSHCN staff, and therapy providers.

Title V CSHCN staff represent the Division of Developmental Disabilities Services on Arkansas' behavioral health System of Care project teams. Staff makes referrals to the project for CSHCN who are dually diagnosed and participate in development of multi-agency plans of care (MAPS) to benefit the CSHCN and their family. Primary care referral and participation in the process is extremely beneficial.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN program supported the CoBalt Project financially during two training sessions over the past year.				X
2. CSHCN staff provided training for the CoBalt sessions on the Title V CSHCN program and DDS programs and services to providers from 5 medical practices around Arkansas.				X
3. Local Title V CSHCN staff attended the training sessions to become part of the local team serving the different areas of the state.		X		
4. The CSHCN program provided financial support for quality assurance and program fidelity evaluations at the local sites.				X
5. Participated in Core AR Links Core Team and the ABCD III Medical Home Committee. Initiative focuses on promotion of Medical Homes with appropriate developmental screening and referrals as appropriate.				X

6. Title V CSHCN staff are involved with pilot community teams with the ABCD III grant funded.				X
7. A CSHCN survey was mailed to randomly selected families that have regular contact with Title V CSHCN staff to determine effectiveness of interactions.				X
8.				
9.				
10.				

b. Current Activities
Helped CoBalt Project financially in 2 trainings this year. Trained on the Title V & DDS programs/services to providers from 5 medical practices around AR. Title V staff attended the training sessions to become part of the local team serving different areas of the state. The sessions were 2-days with the 1st day on training in the diagnosis of Autism, common symptoms & appearance of the diagnosis. The 2nd day in hands-on evaluations of young children (some diagnosed with Autism & some not). Trainees were provided with resources to enable them to begin evaluations in the local practice. Title V provided financial support for quality assurance & program fidelity evaluations at the local sites.

Maintain active membership in ABCD III Medical Home Committee focusing on promotion of Medical Homes with proper developmental screening & referrals. Title V staff involved with local pilot community teams with the ABCD III grant. Project focus: communication link between the Medical Home & providers of EI services to decrease the delay in referral for EI services for children from 0 to 3 yrs.

A survey was mailed to randomly selected families that have regular contact with Title V staff. A cover letter for the survey listed the qualities of a Medical Home. Survey responses related to Medical Home indicate that during the past 12 months, 35% used only the PCP when the child was ill & 90% had at least 1 well child visit. 47% indicate they felt child's PCP met that definition.

c. Plan for the Coming Year
No major change in activities related to Medical Home is anticipated. Will continue to function within the current groups and encourage effective training on Medical Home with the families we serve.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	62	66	67	68	69
Annual Indicator	66.5	66.5	66.5	66.5	63.1
Numerator	493	493	493	493	493
Denominator	741	741	741	741	781
Data Source		Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005	Nat'l Survey of CSHCN

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	65	66	67	69

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Data comes from the National Survey of CSHCN 2005 - 2006.
A survey was mailed to parents/guardians in early 2010. 75.9% answered often or always that "I have insurance to cover my child's health care services." 75% answered often or always to the statement "My child's health problems have an impact on our family." A supposition is made that financial impact is a portion of the family impact.

a. Last Year's Accomplishments
Survey responses on this issue indicate that overall their private or public health insurance or a combination of the two, meets the needs of their child. The following positive responses were received: 83% medication needs met; 71% medical supply needs met; 77% dental care needs met; 62% transportation needs met; and 56% special equipment needs met.

Title V CSHCN program continues to refer for programs and process applications that assist families in the purchase of goods/services not covered by private or public insurance.

Title V Family Support/Respite program served 266 children at a cost of $248,182 during calendar year 2010.

DDS Special Needs program served 51 children at a cost of $49,990 during state fiscal year 11.

Autism Family Support Grant served 754 children at a cost of $1,444,993 during the last 2

quarters of state fiscal year 11.

The Title V CSHCN program served 184 Medicaid recipients in need of services not covered by Medicaid (e.g. medical camp, construction of wheelchair ramps, purchase of van lifts for wheelchairs, non-covered medications such as compounded drugs, rehabilitative services).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Referred families for assistance through the Title V Family Support/Respite program. Title V Family Support/Respite program served 333 CYSCHN for a total of $285,544.		X		
2. Referred CYSHCN for the Special Needs program through the Division of Developmental Disabilities Services. 52 children and youth with developmental disabilities were served at a total cost of $49,938.18 this year.		X		
3. The Title V CSHCN program pays for medical services for children and youth who qualify medically and whose families qualify financially for services.This year 712 children and youth were served.	X			
4. The Title V CSHCN program paid for some services for 166 children and youth that had Medicaid coverage that did not meet their needs. The coverage included purchase of hearing aids; payment for physical or occupational therapy; purchase of braces,etc	X			
5. The Title V CSHCN program paid for 53 children, youth and sometimes their families to attend specialty medical camps during the summer.		X		
6. Title V CSHCN 2012 survey responses on adequate coverage include the following: Does your child's health insurance adequately cover all of his/her needs for medical services?" Yes: 68% No: 24%				X
7.				
8.				
9.				
10.				

b. Current Activities

Title V Family Support/Respite program served 333 CYSCHN for a total of $285,544. Individuals who didn't qualify for that program were often referred for the Special Needs program through DDS. 52 children and youth with developmental disabilities were served at a total cost of $49,938.18.

The Title V program continues to pay for medical services for children and youth who qualify medically and whose families qualify financially for services. This year 712 children and youth were served. Of those, 277 had private insurance that paid for some of their care.

The Title V program paid for some services for 166 children and youth that had Medicaid coverage that did not meet their needs. The coverage included purchase of hearing aids; payment for physical or occupational therapy; purchase of braces, orthotics, medical supplies, special formulas; and purchase of van lifts and wheelchair ramps.

The Title V program paid for 53 children, youth and sometimes their families to attend specialty

medical camps.

Title V 2012 survey responses indicated that 68% felt the health insurance adequately covers all of the child's medical needs; 15% related a delay in the past 12 mos in obtaining medical care or payment for medical equipment/supplies due to a lack of insurance; and only 25% indicated someone had discussed how to get or keep health insurance coverage as their teen becomes an adult.

c. Plan for the Coming Year
No substantive changes in activities are anticipated at this time.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	52	90	90	90	90
Annual Indicator	89.1	89.1	89.1	89.1	64.0
Numerator	688	688	688	688	499
Denominator	772	772	772	772	780
Data Source		Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005	Nat'l Survey for CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	67	68	69	69	70

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised

extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Data comes from the National Survey of CSHCN 2005 - 2006.
Although data for this measure was taken from the National Survey of CSHCN in 2005, the subject was addressed somewhat on a survey mailed to parents/guardians in early 2010. When asked to prioritize the needs of CSHCN in the state, the respondents ranked "community-based services organized so that families can easily access them" as the second priority behind the number one priority of "Adequate Health Insurance".

a. Last Year's Accomplishments
The ABCD-III grant, AR LINKS, moved into the pilot group process in 5 communities statewide. Title V CSHCN staff are involved on the statewide core group as well as in the pilot communities. The focus of the grant project is to improve the linkages and communication between primary care physicians and the providers of early intervention therapeutic services.

CoBalt Project: The Community-Based Autism Liaison and Treatment Project has begun with recent training of the first three local teams each consisting of a Physician and a therapist (preferably a Speech-Language Pathologist). Developed by Dr. Eldon Schulz, Rockefeller Chair, UAMS Department of Developmental Pediatrics, the program emphasizes earlier identification of Autistic Spectrum Disorders and earlier referrals into appropriate services. Title V CSHCN staff participate during the teams' two day intensive training process as well as locally within the community team as a resource for the team and the families of the children evaluated.

Title V CSHCN supported the CoBalt Project financially in 2 training sessions. Providers from 5 medical practices around Arkansas were trained on Title V & DDS programs/services. The sessions were 2 days with the first day training on the diagnosis of Autism, common symptoms and presentation of the diagnosis. The second day consited of hands-on evaluations of young children (some diagnosed with Autism & some not). Trainees were provided with the resources to enable them to begin evaluations in the local practice. Title V provided financial support for quality assurance and program fidelity evaluations at the local sites.

Title V CSHCN staff serve as intake and referral sources for the Alternative Community Services Home and Community based Waiver coordinated by the Division of Developmental Disabilities Services (commonly known as the DDS Waiver). The waiver provides services to assist them in living as independently as possible in the recipients' home community. Over the past year, approximately 1,000 children and youth have been referred for the DDS Waiver with our staff providing the application and assisting in its completion and submission. There are currently over 1,600 names on the waiting list for the waiver and Title V CSHCN staff provides continued assistance as they await waiver services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. The ABCD-III grant, AR LINKS, spread to 5 pilot sites that included local physicians with their office staff, the Early Intervention Service Specialist, and Early Intervention provider network within the community.				X
2. The CSHCN program supported the CoBalt Project financially during two training sessions over the past year.				X
3. CSHCN staff provided training at 2 CoBalt Project sessions on the Title V CSHCN program and DDS programs and services to providers from 5 medical practices around Arkansas.				X
4. Local Title V CSHCN staff attended the training sessions to become part of the local team serving the different areas of the state.				X
5. The CSHCN program provided financial support for CoBalt quality assurance and program fidelity evaluations at the local sites.				X
6. Title V CSHCN staff participates on local community Hometown Health Initiative teams. The local team initiatives are community driven and include projects selected by the community. Examples of targeted issues include physical activity & over-weight				X
7. Title V CSHCN staff serve as intake and referral sources for the Alternative Community Services Home and Community based Waiver coordinated by the Division of Developmental Disabilities Services (commonly known as the DDS Waiver).		X		
8.				
9.				
10.				

b. Current Activities
Title V staff on pilot teams in the ABCD III grant. Project focus: communication link between the Medical Home and the Early Intervention system to decrease the delay in EI services for children from 0 to 3 yrs. A new tool was developed that would shorten the time to initiate evaluations, begin services and improve communication between the physician & the providers of EI services. Modification of the EI data system to create a summary form for the IFSP was recommended. Lack of funding for the system modifications prevents immediate adoption of the recommendations.

Hometown Health: Title V staff participates on local community Hometown Health Initiative teams. The local team initiatives are projects selected by the community. Examples of targeted issues include physical activity, over-weight and obesity, and diabetes.

Staff has submitted over 1200 applications for the DDS Waiver. Waiting list for the waiver is now over 2200.

c. Plan for the Coming Year
Research the possible modification of a current contract between agencies to direct funds to continuing the CoBalt project.

Title V CSHCN staff will continue to work with local, regional and state service programs and agencies to assist CSHCN obtain the services that are needed.

Arkansas will continue the Medicaid payment improvement initiative with a goal to bring Medicaid spending under better control through bundling of payments while improving the care received by

the Medicaid consumers. Pilot projects were selected to determine the impact made by payment improvement. Two of those pilots will impact CSHCN. One is services to individuals with developmental disabilities. During the next year, the process will move toward evaluation of services to children and youth with developmental disabilities and subsequent development of that process. The second pilot is through Behavior Health Services for children and youth with a diagnosis of ADHD with no other co-existing conditions. During the first 6 months, data will be gathered to evaluate the level of care currently being received by children and youth in this group.

A new Alternative Community Services Home and Community Based Waiver will roll out by October 2012. The waiver will target young children diagnosed with Autism. The service provided by the waiver will be intensive therapy. The waiver will serve a maximum of 100 children from 18 months to age 7 years for a maximum of 3 years only.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	15	34	35	36	36
Annual Indicator	33.1	33.1	33.1	33.1	33.1
Numerator	114	114	114	114	98
Denominator	344	344	344	344	296
Data Source		Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005	Nat'l Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	34	34	35	35	36

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001

CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Data comes from the National Survey of CSHCN 2005 - 2006.
A survey mailed to parents/guardians in early 2010 included statements related to transition: "There is someone who has helped us or is helping us find adult care for my child" with a 32% "Yes" response rate and "We are making plans for the time my child becomes an adult" with a 52% "Yes" response rate. In addition, "Transition to adulthood" was listed as one of the "Services received from Title V Children's Services staff". A final question asked the respondents to prioritize the needs of the state's CYSHCN. Transition to adulthood was ranked last under (in order of the ranked priority by respondents) Adequate health insurance; community-based services organized so that families can easily use them; respite care; families as partners at all levels of care and satisfied with services; receiving coordinated, comprehensive, ongoing care within a medical home; and dental health.

a. Last Year's Accomplishments
The Transition Survey is mailed to the home of youth on the Title V CSHCN database in the month of their 14th birthday. A portion of the survey is addressed to the parent/guardian and a portion of the survey is addressed to the YSHCN. Parent responses indicate that, although connected with a medical home and in school with a current IEP, they have not, at this stage of their child's life, begun to prepare for the YSHCN transition into adult life. Requests for information occurred with the majority of the returned surveys and were forwarded to the Title V CSHCN caseworkers to provide the information.

Transition Tip Sheets were developed by the Parent Advisory Council and are shared with YSHCN and their parent/guardians to provide information that will assist in developing transition plans. Tip Sheets discuss topics such as Preparing for the Transition IEP Meeting; Developing the Individual Plan for Employment; Job Accommodations; Self-Determination; Keys for a Successful Transition; Accessing Vocational Rehabilitation; and Person Centered Planning.

Title V CSHCN staff participate in the Interagency Transition Partnership. Agencies representing disabilities, advocates, education, higher education, and vocational rehabilitation meet regularly to provide updates on transition activities and develop strategies for transition in the areas of education, job training and support and independent living.

Title V CSHCN staff participate in regional Transition Fairs which highlight resources available for youth and provide information to the individual to assist them in continuing the transition process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A Transition Work Group was established by the D70 Grant (ARSIP) that meets monthly and includes staff from Arkansas Children's Hospital (Dr. Dennis Kuo), University of Arkansas for Medical Sciences (Drs. Bob Hopkins and Alice Alexander), Title V CSH				X
2. ARSIP Grant sponsored attendance of Title V CSHCN staff at the 2011 annual Transition Conference at Baylor University in Houston.				X
3. The ARSIP Grant invited Dr. Carl Cooley, Got Transition Director, to Arkansas June 4 – 6, 2012. On June 5 Dr. Cooley provided a Grand Rounds presentation on Transition at ACH. Dr. Cooley then met with Title V CSHCN staff from throughout the state.				X
4. The ARSIP Grant is participating in a QI project via distance learning. The project involves Plan Do Study Act 90 day cycles beginning in mid-June 2012. Arkansas has chosen Transition as the area for improvement for the Title V CSHCN program.				X
5. Title V CSHCN surveyed 14 year olds and their parent/guardian on transition plans. The rate of return of the survey over the past year has been disappointing. Of 925 surveys mailed, 138 were returned.				X
6. The Title V CSHCN general survey included questions related to transition. 344 families responded to the survey and of those, 119 (35%) were parents/guardians of youth between the ages of 12 and 20.				X
7. Title V CSHCN staff attend Transition Fairs at school districts around the state providing information to students, parents and teachers.				X
8. Title V CSHCN Parent Coordinator, Rodney Farley, was an active member of the Arkansas Interagency Transition Partnership (a multi-agency organization that looks at youth transition from high school).				X
9.				
10.				

b. Current Activities

Arkansas Systems Improvement Project (ARSIP):
Transition Work Group includes Arkansas Children's Hospital, University of Arkansas for Medical Sciences, Title V & ARSIP staff. Efforts include a "mapping" of specialty areas at ACH & UAMS that function with a transition pathway from child to adult services.

Grant sponsored attendance of Title V staff at the 2011 annual Transition Conference at Baylor University in Houston.

Grant sponsored Dr. Carl Cooley, Got Transition Director, in June, 2012. Dr. Cooley did a Grand Rounds presentation at ACH on Transition, met with all Title V caseworkers and the Transition Work Group.

ARSIP Grant participates in a QI project via video downlink. The project involves PDSA cycles & began in mid-June 2012. Arkansas has chosen Transition as the area for focus for the project.

Title V surveys 14 year olds & their parent/guardian on transition.

Title V general survey had questions on transition. 35% of all responding were parents/guardians of youth between ages 12 & 20. Responses included: 25% said someone had discussed how to obtain/ keep health insurance coverage for the teen; 36% said the teen's PCP encouraged them to take responsibility for their health care needs; and 40% said the PCP talked with the teen about their health care needs as they become an adult.

Title V staff attend Transition Fairs in school districts, AR Interagency Transition Partnership, the Youth Leadership Forum, & the Governor's Commission for People with Disabilities

c. Plan for the Coming Year
ARSIP staff will assist in revision of the Transition survey and process with the goal to improve the response and help guide our program activities.

Completion of the ARSIP QI initiative will occur in mid to late-September. The QI initiative targeted Transition and use of a standard Needs Assessment.

ARSIP Transition Committee will continue to meet monthly and work to promote tools that can be used by specialty areas to assist youth and families they serve to begin the medical transition process.

Title V CSHCN management staff will nominate staff to attend the Transition Conference at Baylor University in Houston.

Rodney Farley, Title V CSHCN Parent Coordinator, will represent the Title V CSHCN program on a committee through Partners for Inclusive Communities, the University Centers for Excellence in Developmental Disabilities Education, Research and Service (UCEDD) in Arkansas. The committee will focus on Policy and Legislation related to disabilities. Public forums will be held statewide to listen on issues related to children and adults with disabilities.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	87	88	80	84	85
Annual Indicator	79.4	77.9	83.0	84.4	86.0
Numerator	5848	6701	5812	5359	6611
Denominator	7363	8601	7000	6348	7683
Data Source		Vaccines For Children Program Co-CASA	Vaccines for Children Program Co-CASA	Vaccines for Children Program Co-CASA	Vaccines for Children Program Co-CASA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	87	88	89	90	91

Notes - 2009
2009 data are from the Comprehensive Clinic Assessment Software Application (Co-CASA) program from the Vaccines for Children (VFC) Program.

The denominator is the number of children sampled at local health units and participating VFC private providers. The numerator is the number of children with coplete vaccine recores from those sampled.

a. Last Year's Accomplishments
The Immunization Section, through each of ADH's local health units, routinely offered all vaccines necessary to age-appropriately immunize children. Each local health unit provided all immunization services and was able to identify children delinquent on needed doses of vaccine. Follow-up activities were initiated and designed to prompt parents/guardians to bring children into clinics to receive needed doses of vaccine. Additionally, the Immunization Section's Vaccines For Children (VFC) regional colleagues promoted immunization activities in private physicians' offices throughout the state. These activities included conducting an assessment of patients' immunization status and providing technical assistance on follow-up activities with children to increase immunization rates. The Immunization Section, through the regional colleagues, continually solicited participation of all clinics, both public and private, to participate in the VFC Program thereby enabling the Arkansas Department of Health to expand availability of services across Arkansas.

The web-based immunization registry continued to enhance overall service delivery activities. It allowed public and private providers quick access to their patients' immunization records and real-time updating of individual immunization records. The Immunization Registry Team continued to place priority on training and recruitment of additional providers to utilize the registry.

During the fall of 2011 and with state and federal funding, local health units worked with school personnel to conduct flu clinics in every public school in the state and in private schools upon request.

An estimated 907 school clinics were held and 145,320 doses of seasonal flu vaccine were administered resulting in 41% of the student population being vaccinated against flu.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All local health units provided currently recommended, age-appropriate vaccinations to infants and young children			X	
2. Parents were prompted to bring children in to local units for		X		

needed vaccinations through a variety of means				
3. Vaccines For Children regional staff worked with private providers to increase immunization rates		X		
4. The web-based immunization registry allowed rapid access by medical providers to children's immunizations status				X
5. Over 145,320 doses of flu vaccine were given in the 907 school flu clinics held during the fall of 2011			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Section, through ADH's local health units, continues to offer all vaccines necessary to age-appropriately immunize children. Follow-up activities designed to prompt parents/guardians to bring children into clinics to receive needed vaccines continue. Regional VFC workers continue to promote immunization activities in private physicians' offices throughout the state as above. Solicitation of additional clinics to participate as VFC providers is ongoing as well.

The Immunization Section continually works to attract more providers utilizing the immunization registry to make a more comprehensive immunization data base with immunization records readily available to both providers and parents. The immunization registry is web-based and currently 100% of the 596 providers report immunization information on a real-time basis or via batch downloads using HL7 to the registry via computers in their offices. The Immunization Section has released a Request for Proposals in an effort to select a new registry for implementation by 2013. A new registry will provide greater access to immunization data and provide the latest in immunization registry functionality.

Effective in 2011, pharmacists in Arkansas are now able to provide immunizations to children age 7 and above.

c. Plan for the Coming Year

The Immunization Section has in recent years implemented newer vaccines in ADH's immunization clinics such as the human papillomavirus (Gardasil), rotavirus, meningococcal (Menactra), pneumococcal for high risk children, adult pertussis (Tdap), and 13-valent pneumococcal vaccine (PCV13) among young children. Beginning in the summer of 2012 and with the use of state funds, LHUs may now offer all ACIP-recommended vaccines to any child through 18 years of age. This includes HPV for males and females and whether or not they are VFC-eligible as well as the catch-up dose of PCV-13 for children ages 24-59 months. The use of these vaccines will remain a high priority in ADH's local health units in an effort to reduce morbidity and mortality associated with these diseases.

The Immunization Section will continue to promote immunization of Arkansas's children through the Vaccines For Children (VFC) Program. The Section will identify areas in the state that have low immunization rates and intensify efforts to immunize individuals delinquent on receiving needed vaccines.

As trends in immunization coverage rates for ages 19-35 months, according to the National Immunization Survey, begin to rise, a concerted effort among public and private providers will continue. Plans include strategic planning with the Vaccine Medical Advisory Committee to develop and target educational efforts among providers and parents. The availability of limited

state funds for vaccine will supplement federal funds to vaccinate all children seeking immunizations in LHUs. Plans also include updating ADH policy to be fully compliant with ACIP recommendations and to propose adding to the immunization requirements for attending day care, school, or college.

The Immunization Registry Team will continue to promote utilization of the web-based registry. During the 2011 legislative session, the registry was expanded from a childhood registry to a lifespan registry. Participation is voluntary, but providers will be required to gain patient consent before reporting adult doses to the registry. With funding through the Prevention and Public Health Fund, ADH is working with 5 external partners to increase adult immunization coverage. The focus will be among long-term care facilities, employer groups, pharmacies, hospitals, and community health centers.

The regional colleagues will continue to promote participation of all immunization providers in the VFC Program. Clinics will be assessed routinely to determine the age-appropriate immunization status of the children they serve so that steps can be taken to increase immunization rates.

School flu clinics are also again being planned for the 2012-2013 flu season. The Section will stay abreast of activities in other states and will implement those activities that have been proven to increase Immunization rates.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	31	32	29.5	27.5	22.5
Annual Indicator	30.8	30.6	29.3	24.5	22.2
Numerator	1813	1780	1686	1427	1293
Denominator	58877	58092	57602	58130	58130
Data Source		2008 Birth Certificates	2009 Birth Certificates	2010 Birth Certificates, US Census Bureau	2011 Birth Certificates, US Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	21.5	21	20.5	20	19.5

Notes - 2011
2010 female population 15-17 years was used to compute 2011 rate.

Notes - 2010
2009 female population 15-17 years was used to compute 2010 rate.

a. Last Year's Accomplishments
Last year saw the start of the activities funded through the PREP Grant. The funds are being used to sponsor a program for teen pregnancy prevention and life skills training for Foster Care Children in Central Arkansas. This has had a very slow start. Gaining the cooperation of Foster Care Teens for participation in the program has been much harder to obtain than estimated. Participation has been low. Changes are being pursued with case managers and court officials that should result in greater participation.

New Abstinence Education efforts have been established in multiple locations around the state, mostly targeted to middle and high school-aged students.

Another new activity was the establishment of the Teen Pregnancy Prevention Action Group under the Natural Wonders Partnership. This group is made up of stakeholders who wish to look for opportunities and synergies in actions that will reduce the number of unintended teen pregnancies in the state. The group meets monthly and is developing an action plan.

Outreach activities through the local health units to bring teens into the family planning clinics have continued. Almost 8,000 teens 17 and under utilized the Title X Family Planning clinics at the Arkansas Dept. of Health in 2011. Priority for appointments and access are given to teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PREP grant funds were used to create a program for teen pregnancy prevention and life skills training for Foster Care Children in Central Arkansas.		X		
2. New Abstinence Education activities were carried out statewide.		X		
3. The Teen Pregnancy Prevention Action Group under the Natural Wonders Partnership was established.				X
4. Outreach activities through the Title X Family Planning clinics at the Arkansas Dept. of Health local health units to bring teens into the family planning clinics have continued.		X		
5. Almost 8,000 teens 17 years old or younger received services through ADH family planning clinics.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The activities described for last years accomplishments have continued into the present. The Teen Pregnancy Prevention Action Group continues to mature and grow. ADH local health units continue local outreach efforts to educate teens on the availability of family planning services. Abstinence Education continues in multiple locations around the state.

c. Plan for the Coming Year
Efforts will continue for the PREP Grant activities for foster care teens in central Arkansas as well as the abstinence education activities around the state. The Teen Pregnancy Prevention Action Group will be considering advocacy for policy change and further development of teen pregnancy prevention activities around the state.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	18	19	18	21	28
Annual Indicator	15.0	17.0	20.2	27.0	27.0
Numerator	197	206	132	1145	1145
Denominator	1312	1214	654	4239	4239
Data Source		Oral Health Branch, ADH	Oral Health Branch	Oral Health Branch, ADH	Oral Health Branch, ADH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	29	30	31	32	33

Notes - 2011
A statewide dental screening survey was not conducted in 2011. Results from the 2010 statewide dental screening survey were used to populate the 2011 measure.

Notes - 2010
A statewide dental screening survey was conducted in 2010 with contract dental hygienists examining children in every county in Arkansas.

Notes - 2009
A statewide dental screening survey was not conducted in 2008. Results are limited to dental screenings done by request of a local agency or organization.

A state-wide, county specific oral health needs assessment is being conducted in 2010. The survey, using contract dental hygienists in every part of the state, intends to screen as many as 9,000 third-grade students in the Spring of 2010.

a. Last Year's Accomplishments
Many programs of the Office of Oral Health (OOH) are funded by the Centers for Disease Control and Prevention (CDC) to augment the state oral health program. With the State Oral Disease Prevention Cooperative Agreement funding of $337,918, the OOH is building infrastructure and

capacity within the State Oral Health program, supporting the Arkansas Oral Health Coalition, Inc. and expanding or creating effective programs to improve oral health outcomes and reduce disparities. CDC grant funding has provided for additional staff, including a state sealant coordinator. The grant also provided funds to better assess oral health in Arkansas, to design new programs on dental sealants, tobacco cessation and prevention, and family violence prevention. The Office of Oral Health, working with the Arkansas Department of Health, various community leaders, organizations and legislators was able to successfully pass three Acts: (1) Act 197, which guarantees fluoridated water to Arkansas citizens who are served by a water system with more than 5,000 customers; (2) Act 89, which allows direct access to a collaborative practice dental hygienist; and (3) Act 90, which enables physicians and nurses to apply fluoride varnish to children's teeth at well-baby checkups. Community water fluoridation has been proclaimed by CDC to be one of 10 great public health achievements of the 20th century. Direct access to dental hygienists and the preventive services they provide as well as fluoride varnish for physicians and nurses address access to care problems as well as oral health issues of young children. Working alongside the Arkansas Oral Health Coalition, OOH continued to support dental sealant programs in the state. The "Seal the State in 2008" project, funded through the Daughters of Charity Foundation, ended in early 2009. Through this project, dental sealant awareness programs occurred in all 75 counties along with direct services for 2,000 at-risk children. Seal the State has grown into a cooperative initiative with Arkansas Children's Hospital that provided dental sealants to children in over 24 school districts in 2011.

Together with comprehensive dental care provided by contract dentists, dental hygiene students from UAMS rotated through a school-based weekly clinic in Little Rock that OOH and partners formed, providing dental sealants to more than 500 children. In western Arkansas, a project in collaboration with Health Connections and UAMS Dental Hygiene Program provided dental sealants to almost 300 students. Other initiatives include numerous presentations on family violence prevention presented to various health care professionals, Head Start agencies and lay audiences. Also, the successful Spit Tobacco Prevention Night with the Arkansas Travelers minor league professional baseball team --based on the slogan, "Spit Tobacco: Chew, Dip and Die," is now in its ninth year and OOH has added a similar event at the Arkansas Naturals ball field in Northwest Arkansas. Head Start dental exams are performed when requested by Head Start staff.

The Office of Oral Health worked with the Chronic Disease Coalition to develop and produce Healthy People 2020 goals for Arkansas. The Office continues to work towards achieving these goals.

In 2011-2012 school year funds from a HRSA grant enabled the Office of Oral Health to hire a contract dental hygienist to visit schools across the state promoting dental health education and awareness. Leslie Patrick, RDH, visited over 30 schools across the state presenting programs to 4th graders and receiving rave reviews.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A state dental sealant coordinator was hired to help design and implement statewide sealant programs				X
2. The Office of Oral Health successfully supported the passage of a mandated fluoridation bill for the state				X
3. The "Seal the State" program provided dental sealants to over 2,000 at-risk children			X	
4. Seal the State also provided dental sealant awareness programs in all 75 counties in the state		X		
5. A collaboration among the Office of Oral Health, the UAMS			X	

Dental Hygiene program, and other partners led to sealant provision for almost 800 additional students in central and western Arkansas				
6. Healthy People 2020 goals related to oral health were established for Arkansas				X
7. Oral Health Awareness Programs were provided to 4th graders across the state		X		
8.				
9.				
10.				

b. Current Activities
The OOH continues to assess oral health across Arkansas, including open mouth surveys for children, adults, and the elderly. A state-wide, county-specific oral health needs assessment was conducted in 2010 to provide 5-year needs assessment to support the MCH Block Grant. The survey, using contract dental hygienists in every part of the state, screened as more than 4000 third-grade students in the fall of 2010.

Oral health workforce initiatives include funding dental recruitment efforts by Delta Dental of Arkansas, providing Grants-in-Aid to new dentists practicing in underserved areas, promoting dental careers in minority and rural populations, and providing in-school instruction in dental careers and oral health.

The CDC grant supports the "Governor's Oral Health Summit," now in its ninth year. The grant also provides additional support for improving the community water fluoridation program in Arkansas. The grant funds educational opportunities to further the acceptance of fluoridation among policy makers, health care professionals, civic leaders, water plant personnel, and citizens, all based on the slogan, "Got Teeth? Get Fluoride!"

The Health Connections Section has developed its ConnectCare contract with Medicaid to establish more positions for the ConnectCare telephone helpline to link Medicaid recipients to dentists throughout the state.

c. Plan for the Coming Year
The Seal the State initiative, now in cooperation with Arkansas Children's Hospital, will target children in all Coordinated School Health schools across Arkansas with the goal of providing free dental sealants to all appropriate school children in Arkansas.

Expansion of community water fluoridation continues to be a major focus for the OOH. Following on the successful signing of legislation guaranteeing access to water fluoridation, OOH is working with the Delta Dental of Arkansas Foundation to provide funding for fluoridation equipment for affected water systems.
Tobacco prevention, injury prevention and family violence prevention are all focus areas for educating healthcare professionals and lay audiences.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	6	6	3.9	3.2	2.6
Annual Indicator	5.7	3.9	3.2	2.7	3.4
Numerator	33	23	19	16	20
Denominator	579442	583073	592002	592125	592125
Data Source		2008 Death Certificates	2009 Death Certificates	2010 Death Certificates, US Census Bureau	2011 Death Certificates, US Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3.1	2.9	2.8	2.7	2.6

Notes - 2011
2010 population estimate of children less than 14 years was used to compute 2011 rate.

The 2011 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These circumstances may ultimately result in a higher mortality rate than is reported for 2011.

Notes - 2010
2009 population estimate of children less than 14 years was used to compute 2010 rate.

The 2010 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These circumstances may ultimately result in a higher mortality rate than is reported for 2010.

Notes - 2009
The 2009 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2009.

a. Last Year's Accomplishments

Overall injury prevention efforts within ADH received a boost during the past year. Late in the summer of 2011, representatives of the State Technical Assistance Team (STAT) of the Safe States Alliance visited ADH to discuss injury prevention activities within the Injury Prevention and Control Branch (IPCB). Members of the Family Health Branch participated in STAT's information-gathering process, which culminated in recommendations that IPCB devote expanded efforts to primary injury prevention in addition to its ongoing trauma system development activities. Around the same time, it was learned that, despite being initially denied, the ADH IPCB was in fact being awarded Core Violence and Injury Prevention Program funds through CDC. Shortly thereafter, the branch established an Injury Community Prevention Group consisting of intra-agency and external stakeholders to set priorities and establish a state strategic plan for injury reduction. The group held its first meeting in November 2011 and now convenes monthly. Several subcommittees have been formed and the group is holding presentations each month on a separate injury prevention priority. In early 2012, a Section Chief was hired to oversee primary injury prevention activities within IPCB. The individual selected, Teresa Belew, has an extensive background in injury prevention within Arkansas and is well-respected.

More specific to childhood motor vehicle safety, the Arkansas Children's Hospital Injury Prevention Center (ACH IPC) continued to set the curve for excellence in its targeted initiatives. ACH IPC continued to provide workshops on child passenger safety, conduct NHTSA training courses to train child passenger safety technicians, conduct child safety seat inspections at various sites around the state, and coordinate distribution of safety seats through community organizations. Additionally, the ACH IPC continued to support safety baby showers in multiple communities which addressed motor vehicle injury prevention and other safety topics. Train-the-trainer sessions were also held in several sites to provide technical assistance to community organizations interested in providing their own safety baby showers.

As reported last year, the ACH IPC received trauma system funds from ADH to provide primary injury prevention activities in communities in partnership with Hometown Health Improvement Coalitions and local hospitals. Staff hired to carry out these activities comprise the backbone for what ACH IPC calls the "State Injury Prevention Program (SIPP)." In 2011, SIPP staff developed a comprehensive injury prevention resource binder containing information on evidence-based injury program implementation, participated in workshops (including one on school bus safety that drew bus drivers from 19 counties), met with hospital personnel to assist in local injury prevention program development (mandated under the trauma system act), and assisted with child passenger safety activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ADH hired a Section Chief to oversee primary injury prevention activities				X
2. ADH established an Injury Community Prevention Group at the state level to set priorities and develop a comprehensive state plan				X
3. The Arkansas Children's Hospital Injury Prevention Center (ACH IPC) continued to provide workshops and other resources				X

on child passenger safety				
4. The ACH IPC conducted safety seat checkups in a variety of locales			X	
5. The ACH IPC coordinated distribution of safety seats to community organizations			X	
6. The ACH IPC provided technical assistance and training to community groups in provision of safety baby showers				X
7. State Injury Prevention Program staff worked with local hospital personnel and Hometown Health Coalitions to establish local injury prevention programs				X
8.				
9.				
10.				

b. Current Activities
As above, the Injury Community Prevention Group meets monthly. The topic for the March 2012 presentation was motor vehicle occupant injury, presented by Dr. Mary Aitken of the ACH IPC. Subcommittees are exploring areas such as recommended policy changes and financing issues.

The ACH IPC continues to pursue all of the activities noted above. IPC staff recently trained a large number of Hometown Health Improvement Coalition personnel in planning and carrying out safety baby showers.

Child Health Promotion Specialists have recently conducted a variety of safety presentations in schools and local health units on car seats, seat belts, all-terrain vehicle safety, and teen driving.

c. Plan for the Coming Year
The Family Health Branch will continue to participate in the Injury Community Prevention Group to provide input on childhood motor vehicle safety and other childhood injury issues. This process should result in stronger ties to the ADH Injury Prevention and Control Branch and other involved stakeholders.

Family Health will also continue to work toward more collaborative efforts with the ACH IPC around child safety. Strong connections already exist to this group through the contract with ACH IPC for infant mortality review development and through other infant mortality initiatives underway.

Other activities underway through ACH IPC will continue.

The state trauma system will continue to grow and adjust to meet local and regional needs (see also SPM3).

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	25	26	27	28	26
Annual Indicator	23.4	26.4	26.6	24.0	27.9
Numerator	8913	10147	10016	8884	10027
Denominator	38017	38428	37653	37077	35936

Data Source		2007 PRAMS survey	2008 PRAMS Survey	2009 PRAMS Survey	2010 PRAMS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	28	30	31	32	33

Notes - 2011
2011 data are from the 2010 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2010.
Numerator is total (weighted) number of women who responded 'Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2010 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

Notes - 2010
2010 data are from the 2009 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2009.
Numerator is total (weighted) number of women who responded 'Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2009 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

Notes - 2009
2009 data are from the 2008 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2008.
Numerator is total (weighted) number of women who responded 'Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2008 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

a. Last Year's Accomplishments
In recent years, most ADH breastfeeding promotion efforts have been conducted through the Nutrition and WIC Branch within the Center for Health Advancement. A sampling of their many efforts last year in this important endeavor are as follows:

Breastfeeding education updates were made available to community health professionals statewide including ADH and WIC staff in 10 one-hour formats utilizing the statewide video conferencing system through the University of Arkansas for Medical Sciences Education Network,

ANGELS. The video conferencing sessions were accessed by up to 40 viewing sites across the state and some border state locations. This initiative was sponsored in part by the Arkansas Breastfeeding Education Partnership that includes Arkansas Department of Health-WIC, Arkansas Children's Hospital and the University of Arkansas for Medical Sciences College of Medicine.

Access to the Gold-Online 2011 Lactation Conference was provided to 12 select WIC staff to provide more in-depth education and updates during the month of May 2011.

"The Loving Support to Grow and Glow in WIC: Breastfeeding Training for Local WIC Staff" was offered to new WIC staff in face to face regional trainings. In addition, a complementary AR WIC developed online self-study module became available for WIC counselors in September 2011. Continuing education credits were available for the self-study format for nurses and RD's through the agency web-based staff training tracking system (A-Train). The national WIC Works Online Learning "Breastfeeding Basics" training was also utilized for some components of the breastfeeding orientation when warranted.

An annual summer workshop for breastfeeding peer counselors featured an extensive presentation on etiquette in the WIC clinic and environment.

To show its commitment to the Peer Counselor Program, AR WIC State Office staff attended the USDA SW Region Train-the --Trainer workshop for the newly revised module "Loving Support Through Peer Counseling: A Journey Together" in October 2011. The new curriculum is being used for all peer counselor trainings.

AR WIC continued the distribution of the Loving Support breastfeeding education bag collaborative project from the USDA SW Region states. AR WIC distributed 30,000 bags to 93 WIC clinics over an 18 month period.

A street bus ad breastfeeding campaign "Breastfeeding in Motion" was implemented in Fort Smith, AR for a one year period featuring participants of the Fort Smith WIC Clinic breastfeeding support group. A poster session on the campaign was displayed at the 2011 International Lactation Consultants Association Conference in San Diego and in May 2012 at the National WIC Association Conference.

During World Breastfeeding Week/Month, radio breastfeeding PSA's were aired across the state featuring ads from the Texas WIC "Every Ounce Counts" breastfeeding campaign. In addition, 13,000 Lullaby CD's from the same breastfeeding campaign were distributed through WIC clinics and community health fairs statewide.

In early 2012, AR WIC co-sponsored a pre-recorded one-day lactation webinar event for 40 select staff and community health professionals from across the state. This event provided five hours of lactation specific education credits as well as a networking opportunity between WIC and hospital based lactation consultants.

A toll-free Breastfeeding Helpline was operational. Each Health Unit has an on-site breastfeeding contact person to coordinate the local breastfeeding support and promotion plan. Local Health Unit staff maintained a clinic environment that endorsed breastfeeding. For example, there is a requirement that no formula displays or items displaying formulas or company names can be displayed. Areas are designated for moms who want or need to breastfeed. Each Local Health Unit provided at least one breastfeeding promotion project for the year, which included health fairs, lobby or clinic displays, and participation in World Breastfeeding Week displays.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Video-conferencing educational sessions were provided to health professionals statewide in partnership with UAMS and Arkansas Children's Hospital				X
2. Access to the Gold-Online Lactation Conference was provided to key WIC staff				X
3. Breastfeeding training for staff new to the WIC program was provided in regional trainings and through online self-study modules				X
4. An annual summer workshop for breastfeeding peer counselors was held				X
5. State Office WIC staff attended a USDA regional train-the-trainer workshop related to a newly revised training module for peer counselors				X
6. 30,000 education bags were distributed in 93 WIC sites as part of the USDA SW Region Loving Support education bag collaborative project		X		
7. A street bus ad campaign was launched in Fort Smith featuring participants in the local breastfeeding support group, with results reported at national meetings		X		
8. Breastfeeding PSA's were aired on radio stations statewide, and 13,000 breastfeeding CD's were distributed at WIC clinics and health fairs		X		
9. The WIC program co-sponsored a one-day lactation webinar event for health professionals and staff				X
10. A toll-free breastfeeding helpline remained in place; local health units had practices and policies in place to promote breastfeeding				X

b. Current Activities

The Loving Support to Grow and Glow in WIC: Breastfeeding Training for Local WIC Staff continues for new WIC staff in face-to-face regional trainings in addition to the AR WIC online self-study modules and the WIC Works Online Learning "Breastfeeding Basics" modules.

USDA Southwest Region states have continued the Loving Support breastfeeding education bag collaborative project.

A monthly breastfeeding "Quick Notes" newsletter is sent out to all WIC staff through each Local Health Unit breastfeeding contacts.

AR WIC participated in the Cinco de Mayo celebration in Northwest Arkansas and purchased a breastfeeding promotion ad for the Hispanic newspaper in April 2012. WIC staff manned a booth and provided education and information for the event.

An extensive article on breastfeeding and the AR WIC program is being submitted to professional journals, parenting magazines, and newspapers across the state for consideration for publication. The AR State Board of Nursing journal featured the article in the June 2012 publication.

The breastfeeding peer counselor annual summer workshop in June 2012 featured a 3 day training presentation on "The Secrets of Baby Behavior" from "The Fit WIC Baby Behavior Study" that was funded by a USDA WIC Special Projects Grant from CA WIC and UC-Davis.

Five additional part-time breastfeeding peer counselors were recently trained to serve the ADH

Central and NE regions.

c. Plan for the Coming Year
The "Using Loving Support to Grow and Glow in WIC: Breastfeeding Training for Local WIC Staff" will continue to be offered to new WIC staff in face-to-face regional trainings. In addition, staff that are new to the WIC program must complete an online self-study module that became available September 2011. Continuing education credits are available from the self-study format for nurses and RD's. The national WIC Works Online Learning "Breastfeeding Basics" training will also be utilized for some components of the breastfeeding orientation when warranted.

The "Loving Support Breastfeeding Education Bag" project for pregnant women will be offered statewide for prenatal participants during the 2012/2013 funding year and will continue as funding is made available. Arkansas has utilized the education bag project each year and will distribute 27,000 education bags to 93 clinics during this fiscal year as part of the required nutrition education-breastfeeding promotion to pregnant women at the initial WIC certification. Funding has been received to continue the bag project for the 2013 federal fiscal year.

AR WIC has launched a statewide street bus campaign of breastfeeding promotion ads, entitled "Think Breastfeeding! Think WIC!" The campaign is an extension of the Fort Smith campaign that ran 2010-1011. The statewide campaign will begin in June and July of 2012 and will run for 6 months in Little Rock, Jonesboro, Texarkana, Fort Smith and the Northwest Arkansas Transit area that covers Fayetteville, Bentonville, Springdale & Rogers and for one year in West Memphis.

Breastfeeding promotion activities are planned for the month of August to celebrate World Breastfeeding Week and Month. Each Health Department region has developed a plan to address components of the Arkansas WIC breastfeeding policy, "Breastfeeding Best Practices Action," to address increasing breastfeeding initiation and duration and increasing WIC staff communications.

The ADH WIC program will continue to seek funds to expand the peer counselors' effort. One full time peer counselor position has recently been approved for the West Memphis WIC clinic along with an additional part-time position for the Central region.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	98.3	98.4	99	99	99
Annual Indicator	98.2	99.0	98.9	98.9	98.3
Numerator	38978	38468	37457	36522	36957
Denominator	39682	38865	37883	36939	37615
Data Source		ADH Infant Hearing Program	ADH Infant Hearing Program	ADH Infant Hearing Program	ADH Infant Hearing Program
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	99	99	99	99	99

Notes - 2011
The denominator is the number of forms received from birthing hospitals (37,615).

The numerator is the number of infants reported on forms that received hearing screens before hospital discharge (36,939).

Notes - 2010
The denominator is the number of forms received from birthing hospitals.

The numerator is the number of infants reported on forms that received hearing screens before hospital discharge.

Notes - 2009
The denominator is the number of forms received from birthing hospitals (37,883). The numerator is the number of infants (reported on forms) that received hearing screens (37,457) before hospital discharge.

a. Last Year's Accomplishments
Efforts were focused on the design and implementation plan of the Infant Hearing Module of the Electronic Registration of Arkansas Vital Events (ERAVE) system. The Infant Hearing Module will link to the electronic, on-line Birth Certificate Registry and Death Registry Programs when fully implemented.

Early Hearing Detection and Intervention (EHDI) education and awareness activities included the provision of sponsorship of staff and parent attendance at several conferences promoting the early identification of and appropriate interventions for hearing loss; Spanish interpretation/translation and support services for parents and parent assistance groups were provided; an annual hospital nursery nurse's workshop in the area of newborn screening was offered; and site visits to birthing hospitals for quality assurance and in-service training continues. In an effort to offer families increased options for follow-up from failed hospital hearing screening, Phase I of a collaborative pilot project with the University of Arkansas Medical Sciences, Department of Audiology was completed and Phase II was started. The collaborative project offers follow-up with parents through extended (after work hours) contact and free repeat hearing screenings at six different sites across the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Birth hospitals were provided with technical assistance in physiologic testing and data submission				X
2. An algorithm for matching infant hearing screens compared to birth certificate data is currently utilized to identify any unreported newborns from the birth hospital. Reports are sent to the reporting hospitals				X
3. The program was guided by an advisory council of experts				X
4. The program worked with Part C Early Intervention to assure needed services for children with diagnosed hearing loss				X
5. The program worked with Vital Records to link data input with the new web-based registry				X
6. Abnormal hearing screens reported were identified and parents, physicians and providers were notified of the need for follow up. Written and telephone contacts were made to assure needed follow up			X	
7. Confirmatory audiologic diagnostic testing results were reported to the database			X	
8. Family support services were provided via parent group that is unbiased towards communication modes and methods		X		
9. Translation services for families in need were provided via outside entity		X		
10.				

b. Current Activities

The Program successfully completed the user acceptance-testing phase 5 of the electronic Infant Hearing Module of the ERAVE system. The Infant Hearing Program (IHP) is in the final stage of materials development in preparation to provide training to the stakeholders on the Electronic Registration of Arkansas Vital Events (ERAVE) Infant Hearing Module of database system.

The IHP Follow-up Coordinator makes site visits to birthing hospitals to offer technical assistance and ensure that the facility is following newborn hearing screening protocol. This is a quality assurance tool for the program.

The IHP will participate in the National Initiative on Child Health Quality (NICHQ) Learning Collaborative to identify points in the hearing screening and early intervention system where babies and families get "lost" and to help with identification of changes that prevent that from happening.

The IHP Manager, advisory board president, and the Follow-up Coordinator are working with the Advisory Board to revise the State's written guidelines for birthing hospitals and other providers that screen newborns for hearing loss according to the JCIH 2007 guidelines.

The Infant Hearing Program is sponsoring radio broadcasts of public service announcements and call-in spots regarding hearing screening. The campaign targets the Hispanic population in Arkansas. The IHP also plans quarterly Early Hearing Detection and Intervention (EHDI) Stakeholder meetings as a networking strategy.

c. Plan for the Coming Year

The Infant Hearing Program (IHP) will:

1. Focus efforts on the implementation, go-live, and rollout phases of the Infant Hearing Module of ERAVE
   database system;
2. Provide training on ERAVE to users such as PCPs, clinics, and hospitals as well as provide

continuous
helpdesk support; IHP will also provide appropriate system enhancements if required by the users or
stakeholders;
3. Continue to support parent and other stakeholder attendance at conferences/trainings promoting newborn
earing screening, tracking, and early intervention;
4. Collaborate with Outreach Services at the Arkansas School for the Deaf to provide regional assistance for
hearing screening and diagnostic audiology services;
5. Continue the equipment loaner program that enables Universal Newborn Hearing Screening
hospitals to borrow equipment when their own instruments are down for repairs;
6. Continue to work with Part C and other early intervention service providers in order to improve data
exchange and reduce the number of children who are loss to follow up for Early Intervention services.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10.8	10.8	6	8.5	10.5
Annual Indicator	9.3	6.2	9.2	11.5	7.4
Numerator	65167	44425	65157	81196	52481
Denominator	698812	719784	710422	707494	710351
Data Source		US Census Bureau	US Census Bureau	US Census Bureau	US Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7	6.8	6.5	6	5.5

Notes - 2011
2011 indicator populated with 2010 data.

Data source: U.S. Census Breau, Current Population Survey, Annual Social and Economic Supplement, 2011

Notes - 2010
2010 indicator populated with 2009 data.

Data source: U.S. Census Breau, Current Population Survey, Annual Social and Economic Supplement, 2010

Notes - 2009
2009 indicator populated with 2008 data.

Data source: U.S. Census Breau, Current Population Survey, Annual Social and Economic Supplement, 2009

a. Last Year's Accomplishments
In response to requirements imposed on states by the 2010 Affordable Care Act, the Arkansas legislature decided in 2011 not to establish its own health care exchange to help provide coverage for individuals not covered by other mechanisms, but rather to allow the federal authorities to establish one for the state. Although some activity has been pursued in this regard, to date no exchange has been created.

Once again in 2011, the expansion of Medicaid/ARKids B eligibility to 250% of FPL that was originally authorized legislatively in 2009 failed to occur, due to continued budgetary concerns. The state Medicaid program proceeded with plans to overhaul the system of reimbursement due to projected shortfalls in the program approaching $400 million by the year 2014. Nine priority health "episodes" have been chosen as initial targets for bundled payments and other reimbursement innovations. For each of these targeted episodes, Arkansas Medicaid has established a committee that includes provider stakeholders to help hash out payment issues and possible solutions. Although the final outcome of this process remains unpredictable at this point, it is clear that no consideration of expansion of Medicaid/ARKids eligibility will occur until the current fiscal crisis is resolved.

The state Finish Line Coalition sponsored through Arkansas Advocates for Children and Families continued to meet to discuss potential enhancements to health care access for children. Two measures supported by this group were enacted by the Arkansas General Assembly in 2011, as reported last year. One law provided assurance that the intent of the federal Affordable Care Act with respect to coverage of children would be carried out by mandating all state insurers to offer policies for children without regard to pre-existing health conditions. The other law required the state Department of Human Services (which houses the Medicaid program) to streamline re-enrollment for ARKids A and ARKids B recipients through use of readily available databases to verify income and other eligibility information.

Supported by the "ConnectCare" contract with Arkansas Medicaid, the ADH Health Connections Section (HCS) within the Family Health Branch continued health education and outreach targeted to areas of the state with high Medicaid-eligible populations. Such efforts included targeting schools with high free-lunch program participation and the 11 schools with health/wellness centers. HCS health educators continued to work with school nurses and school-based human service workers (who help enroll eligible children), and also produced newsletters, brochures and other materials on health topics for distribution to Medicaid beneficiaries. Under contract with Arkansas Medicaid, the Health Connections Section also continued operation of the ConnectCare telephone hotline from 6 a.m. to 10 p.m. Monday through Friday. The hotline assisted Medicaid/ARKids First beneficiaries in identifying and becoming assigned to primary care physicians and dentists. The helpline also provided other health resource information to callers. Availability of at least one bilingual operator for physician assignments and one for dental provider assignments assured that Spanish-speaking callers received needed services. Attention to Arkansas's shifting demographics was further exemplified through employment of a bilingual Outreach Coordinator who focused her efforts on regions of the state with high Hispanic populations. This individual also worked closely with groups such as Arkansas League of United Latin American Citizens (LULAC), the Catholic Diocese, and Head Start to reach families of eligible Hispanic children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Laws were enacted by the AR General Assembly related to Medicaid re-enrollment enhancements and guarantees that children could obtain coverage by private insurance carriers without regard to pre-existing conditions				X
2. The ADH Health Connections Section provided outreach and on-site primary care physician assignments at targeted high-need schools		X		
3. Health Connections staff provided health education to Medicaid beneficiaries and their families through a variety of media and venues		X		
4. Health Connections staff operated the ConnectCare helpline which linked Medicaid beneficiaries with primary care physicians and dentists		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Development of a state health exchange is proceeding, albeit slowly, under the auspices of the State Insurance Commission in collaboration with federal partners. The pace of action is expected to accelerate if the Supreme Court upholds key provisions of the Affordable Care Act.

The Department of Human Services is proceeding with phased implementation of the law which requires streamlining of the Medicaid re-enrollment process (Act 771 of 2011).

Health Connections Section continues all of the above activities.

The Family Health Branch continues to monitor and participate in the activities of groups such as the Finish Line Coalition that are devoted to assuring access to health coverage for all children.

c. Plan for the Coming Year
Family Health Branch staff will continue to participate in state-level activities aimed at assurance of health coverage for all children. Progress in development of a state health care exchange will be closely monitored.

Family Health Branch staff will continue to monitor and particpate in the Medicaid reimbursement system change planning to the extent allowed, which may ultimately alter access to some services even if the same number of children remain Medicaid-eligible.

Family Health staff will work with Medicaid to encourage full implementation of Act 771 so that fewer children are dropped from coverage due to administrative reasons.

The ConnectCare contract with Arkansas Medicaid is being renewed and the Health Connections Section will continue to provide Medicaid beneficiaries with linkage to primary care physicians and dentists. Provision of health education to beneficiaries and outreach to potentially eligible populations and assistance in enrollment will also continue.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	12.9	12.9	15.5	16	29
Annual Indicator	15.8	29.8	30.1	30.3	30.6
Numerator	5590	11500	12723	9883	13044
Denominator	35378	38591	42270	32615	42626
Data Source		2008 WIC-PEDNSS	2009 WIC-PEDNSS	2010 WIC-PEDNSS	2011 WIC-PEDNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	28.5	28	27.5	27	26.5

Notes - 2011
Data sourec: Pediatric Nutrition Surveillance System (PEDNSS), CDC.

Notes - 2010
The increase in the percentage is due to previous years' reporting of children 2-5 years that were in the 85th to 95th percentile of height to weight ratio only. This was incomplete reporting as the percentage did not include children with BMI at or above the 95th percentile. These data were presented as reported by WIC. However, this oversight has been realized and the correct data are now presented.

The correct percentage for 2006 is 28.4% (8,088 / 28,481).
The correct percentage for 2007 is 30.0% (10,614 / 35,378).

The majority of children receiving WIC services are preschool age children.
Data are from the PEDNSS report provided by CDC.

Notes - 2009
The increase in the percentage is due to previous years' reporting of children 2-5 years that were in the 85th to 95th percentile of height to weight ratio only. This was incomplete reporting as the percentage did not include children with BMI at or above the 95th percentile. These data were presented as reported by WIC. However, this oversight has been realized and the correct data are now presented.

The correct percentage for 2006 is 28.4% (8,088 / 28,481).
The correct percentage for 2007 is 30.0% (10,614 / 35,378).

The majority of children receiving WIC services are preschool age children.
Data are from the PEDNSS report provided by CDC.

a. Last Year's Accomplishments
As in previous years, children participating in WIC were prescribed food packages based upon age, but tailored to fit individual needs. All participants received nutrition education designed to address immediate concerns and improve overall health. In addition, one-on-one nutrition counseling with a Registered Dietitian regarding specific nutrition-related health problems continued to be available in local health units.

WIC also administered the Farmers' Market Nutrition Program (FMNP), the mission of which is to encourage the consumption of fresh fruits and vegetables and encourage the development of farmers' markets. Women and children residing in counties with farmers' markets were eligible to receive food coupons which could be redeemed for fresh produce during summer and early fall months.

Last year the WIC Program began using a new tool to help participants achieve a positive change in nutrition-related behaviors/habits. The Circle Chart for Primary Nutrition Education flipchart is designed to help the WIC Competent Professional Authority (CPA -- a person qualified to certify WIC participants) to engage with participants and provide them with the opportunity for questions and feedback. It is available in English and Spanish. Training in use of the flipchart took place at 10 sites (2 in each region) in 2010 and 2011. Associated with the flipchart are Circle Chart Posters intended to ready participants for their visit with the CPA, which are displayed in local health unit waiting areas. The posters contain samples of nutrition topics that are found in the flipchart and display the message: "What Would YOU Like to Talk About?" Circle Chart Goal Handouts (printed in both English and Spanish) were also utilized as a tool to identify participant pressing concerns prior to their visit. These handouts provide a space for participants to list a health-related behavior change goal and contain a website link for additional nutritional information.
There are two adjunct tools that accompany the Circle Chart Flipchart.

More specific to overweight prevention among WIC children, the classification of children as "overweight" if over the 85th percentile for BMI, and "obese" if over the 95th percentile, has been incorporated into the Value Enhanced Nutrition Assessment (VENA). This change will alter the nutritional counseling provided to parents of children in these ranges, hopefully leading to behavior changes at an earlier stage of overweight.

Also in an effort to encourage healthier eating, Arkansas WIC staff began work last year on a cookbook containing appropriate recipes for WIC recipients. All the recipes included will meet National WIC Association guidelines for recipe development, which encompass USDA Dietary Guidelines for Americans and American Academy of Pediatrics recommendations. The cookbooks will be provided to WIC participants who keep their nutrition education appointments. Recipe cards excerpted from the cookbook featuring in-season fruits and vegetables will also be disseminated at farmers' markets during the months of May through July.

Other activities Arkansas WIC has recently been involved in include training of staff on revisions to the SPIRIT data system and continued work on transition to an Electronic Benefits Transmission system.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC participants received individual nutrition education		X		
2. WIC administered the Farmers' Market Nutrition Program,		X		

providing coupons redeemable for fresh produce at farmers' markets				
3. WIC implemented the Circle Chart for Primary Nutrition Education flipchart, placed related posters in local health units, and utilized the Circle Chart Goal handouts		X		
4. The classification system for overweight children seen through WIC was revised, changing the risk category for such children through the Value Enhanced Nutrition Assessment				X
5. Arkansas WIC began work on a cookbook featuring healthy recipes, to be provided to participant families at nutrition education visits		X		
6. Recipe cards featuring in-season fruits and vegetables were distributed at farmers' markets		X		
7.				
8.				
9.				
10.				

b. Current Activities
1. WIC continues the activities described above.

2. Online training on the new classification system and counseling for BMI measurements >85th percentile will be completed by all CPAs in July 2012.

3. The Arkansas plan for transition to WIC Electronic Benefit Transmission (EBT) has very recently been approved by USDA.

4. Work on the Arkansas WIC cookbook is being finalized. Information provided will include appropriate serving sizes along with detailed nutritional analysis of each of the recipes. The cookbooks should be ready for distribution a little later this year. Recipe cards featuring in-season fruits and vegetables are currently being distributed at local farmers' markets around the state.

5. Training is ongoing for new staff on the SPIRIT data system and as additional needs are identified.

c. Plan for the Coming Year
1. Continuation of current activities as described.

2. As per USDA rule, growth charts used by WIC programs will change October 1, 2012 from the traditional CDC chart to the World Health Organization growth chart. How this change will affect percentages of overweight children is uncertain at present, but it may lead to a larger proportion being categorized as overweight or obese.

3. The new Electronic Benefit Transmission system will be piloted beginning in 2013.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011

Performance Data					
Annual Performance Objective	20.9	20.7	18.5	19.5	18.5
Annual Indicator	19.4	18.8	24.0	18.8	18.5
Numerator	7326	7099	8866	6853	6639
Denominator	37683	37857	36987	36416	35936
Data Source		2007 PRAMS Survey	2008 PRAMS Survey	2009 PRAMS Survey	2010 PRAMS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	17.6	17.3	17	16.5	16

Notes - 2011
2011 data are from the 2010 PRAMS survey.

Notes - 2010
2010 data are from the 2009 PRAMS survey.

Notes - 2009
2009 data are from the 2008 PRAMS survey.

a. Last Year's Accomplishments
ADH continued to screen all Maternity, Family Planning, WIC and STI clients for tobacco usage. Information and cessation resources were provided to all interested clients in English or Spanish. At minimum all smokers were referred to the Arkansas Tobacco Quitline. The financial incentive project being conducted by the Tobacco Prevention and Cessation Program to encourage pregnant women to stop tobacco use was expanded. Incentive payments were raised last year in order to encourage higher rates of participation in the program. Pregnant women in this trial may receive a total of approximately $1000 if they successfully remain tobacco free during the entire pregnancy. Urinary cotinine is measured at every visit to insure compliance.

The Fax referral system has allowed prenatal care providers in the state to identify their patients using tobacco, advise them to quit and easily refer them to the Quitline for extensive counseling by highly trained individuals without using a large amount of their own staff time and resources. The Quitline provides feedback on client services received to all HIPAA-covered providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Women seen through ADH prenatal clinics were screened for tobacco use and referred to the Arkansas Tobacco Quitline		X		
2. The Tobacco Prevention and Cessation Program conducted a pilot cash incentive project for pregnant women in several counties		X		
3. The fax referral system allowed private providers to refer their		X		

patients for Quitline services in an expeditious manner				
4. The Quitline system provided feedback to referring medical providers on cessation services rendered				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The pilot incentive program is being expanded. It is currently still under evaluation. All ADH local health unit staff are encouraged to ask all clients (at every visit) if they are currently using tobacco, inform them it is dangerous both for themselves and their children, and offer referral to the AR Quitline for convenient in-home counseling. TPCP has also worked with private medical providers to encourage them to do the same. It is disappointing that the percent of women smoking during the last 3 months of pregnancy has remained close to 19% for the past five years (PRAMS 2006---19.4; 2010---18.5). Of more concern has been the increase in 18-44 year old AR women smokers (BRFSS 2007---22.2%; 2010---24.5%). The best known method to prevent tobacco use or increase cessation has proven to be large increases in tobacco taxes; ADH continues to educate the state legislature in this regard.

c. Plan for the Coming Year

As a state with one of the highest tobacco usage rates in the nation, Arkansas continues to use evidence-based methods of cessation and prevention to fight this powerful addiction. We will also continue to try new and innovative methods to combat the problem. Family Health will continue to cooperate with TPCP on the cash incentive project, support current policies related to tobacco screening and referral, and participate in legislative planning efforts as allowed.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	9	8	10	7	7
Annual Indicator	8.1	10.6	7.0	7.4	9.8
Numerator	16	21	14	15	20
Denominator	197560	197229	199339	203805	203805
Data Source		2008 Death Certificates	2009 Death Certificates an US Census Bureau	2010 Death Certificates, US Census Bureau	2011 Death Certificates, US Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	9	8.5	7.5	7.3	7

Notes - 2011
2010 population estimate 15-19 years was used for 2011 rate.

The 2011 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These circumstances may ultimately result in a higher mortality rate than is reported for 2011.

Notes - 2010
2009 population estimate 15-19 years was used for 2010 rate.

The 2010 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These circumstances may ultimately result in a higher mortality rate than is reported for 2010.

Notes - 2009
The 2009 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2009.

a. Last Year's Accomplishments
A number of groups dedicated to suicide prevention continued operation in Arkansas during the past year. Coordination of these efforts had been taking place under the umbrella of the Arkansas Suicide Prevention Network, but the retirement of a key figure, Capt. Tanya Phillips of the Arkansas National Guard, posed a setback to Network activities. Nonetheless, groups such as the Arkansas Chapter of the American Foundation for Suicide Prevention (AFSP) pressed on with a multitude of projects. AFSP sponsored campus walks at colleges and an Out of the Darkness Walk for the general public in Little Rock, addressed teen depression on a state

television network, provided presentations to several classes at Central High in Little Rock during a health fair event, presented the More Than Sad: Teen Depression video to multiple community groups, and spoke with medical students about their personal experiences with suicide loss. The chapter also operated a statewide crisis hotline. For its outstanding efforts, AR AFSP was named "Chapter of the Year" at the Advocacy Forum and Leadership Conference in Arlington, VA earlier this year.

The Arkansas Department of Education worked to implement provisions of the Jason Flatt Act of 2011, which requires teachers to obtain in-service training in youth suicide awareness and prevention every 5 years. Teachers can now access the Gatekeeper program online to meet this requirement. Other opportunities to meet the requirement include the More Than Sad curriculum and a soon-to-be released online curriculum sponsored by the Jason Foundation.

In Northwest Arkansas, the Arkansas Crisis Center (located in Springdale) continued to provide Applied Suicide Intervention Skills Training (ASIST) at regional sites. These trainings were designed to give caregivers tools to recognize risk and intervene in crisis and pre-crisis situations to prevent suicide.

The state Attorney General's Office also continued its Youth Suicide Prevention Program. Activities included a youth poetry contest, poster contest, and PSA production contest. Winning PSA videos are featured on the Attorney General's website and YouTube.

The Arkansas Youth Suicide Prevention Task Force continued to meet quarterly despite a lack of continued funding. At present no new appointments are being made to the Task Force, but the lack of a "sunset clause" in the original legislation is expected to be addressed later this year. It is possible that the group's activities will be revived in the next Arkansas General Assembly.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Arkansas Chapter of AFSP staged campus and community walks, provided presentations at high schools, operated a hotline, provided media interviews on teen suicide, and worked with medical students.		X		
2. Arkansas Department of Education worked to implement provisions of the Flatt Act of 2011				X
3. The Arkansas Crisis Center provided trainings and other resources at regional sites				X
4. The AR Attorney General's Office sponsored poster, poetry, and PSA contests for youth to raise awareness and promote prevention		X		
5. The Arkansas Youth Suicide Prevention Task Force continued to meet to develop strategies				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The AR Chapter of AFSP continues to pursue multiple activities related to youth and adult suicide prevention.

Arkansas Department of Education continues to seek acceptable training curricula to allow educators to meet the requirements of the Jason Flatt Act.

The Attorney General's Office has received submissions for the 2012 contests and will announce winners soon.

The Arkansas Youth Suicide Prevention Task Force continues to meet quarterly.

c. Plan for the Coming Year
Groups such as AR AFSP and the Arkansas Crisis Center will continue to provide both emergency and prevention services.

ASIST Trainings will continue to be offered in Northwest and Central Arkansas at regular intervals by certified trainers.

Department of Education training curricula will be available to teachers by the end of June 2012.

Attorney General's Office activities will continue as above.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	69	70	70	71	71
Annual Indicator	58.8	64.6	69.3	69.1	71.2
Numerator	448	451	462	428	436
Denominator	762	698	667	619	612
Data Source		2008 Birth Certificates	2009 Birth Certificates	2010 Birth Certificates	2011 Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	72	72	73	73	74

Notes - 2011
2011 indicator represent data from Federal Fiscal year 2011.

Arkansas (AR) is currently considering its first NICU hospital level designation. National

standards are in the process of revision by AAP/ACOG and are to be released this fall with major revisions anticipated. AR is anticipating complying with the majority of the new revised national standards but has not been able to review them to this point. Currently 50% of these deliveries are occurring in Level I and II “equivalent” facilities. Our goal for next year is to have 85-90% of these deliveries occurring in Level III facilities. National studies have shown a 50% decrease in IMR for mothers < 29 weeks that are transported to Level III facilities for delivery

Notes - 2010
2010 indicator represent data from Federal Fiscal year 2010.

Notes - 2009
2009 indicator represent data from Federal Fiscal year 2009.

a. Last Year's Accomplishments
ADH local health units have continued to collaborate with UAMS to provide prenatal care to high risk women through an interagency contract that includes provisions for telephone and telemedicine consultations with maternal-fetal medicine (MFM) specialists. Recommended referrals for delivering these high risk mothers at appropriate facilities should significantly lower the infant mortality rate of these very low birth weight infants.

The UAMS ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) Call Center continued to provide 24/7 statewide services to both physicians and patients. Calls are screened by experienced nurse practioners with immediate access to in-house MFM specialists. A pilot program to provide evening and weekend availability of the call center to ADH maternity patients lacking a current physician has been a success and will be expanded statewide. It is anticipated that this will significantly improve their quality of care and decrease unnecessary utilization of hospital ER facilities on nights and weekends.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ADH collaborated with UAMS to provide prenatal services for high-risk women utilizing phone and telemedicine modalities	X			
2. UAMS directed referral of high-risk pregnant patients to appropriate tertiary care facilities		X		
3. The ANGELS Call Center served both physicians and patients		X		
4. The ADH Director convened a working group to explore and make recommendations regarding neonatal/perinatal levels of care designations				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
ADH in collaboration with the Arkansas Hospital Association (AHA), the March of Dimes (MOD), Arkansas Children's Hospital (ACH), UAMS, and representatives of delivering obstetricians, pediatricians, and neonatologists have formed an advisory committee to make recommendations to the Director of ADH for establishing the state's first system for designating and developing referral recommendations for regionalized NICU facilities. Soon-to-be released revisions of national guidelines pertaining to NICU designations are also being incorporated into Arkansas's

new recommendations. An intensive education effort on the benefits of a regionalized system of referrals for delivery at "Level III" facilities for patients less than 29 weeks gestation is underway for hospital administrators and physicians. It is likely that the annual indicator would be different (probably decreased) had official designations of care facilities already been made. Regardless, if desired system changes are achieved whereby 90% of deliveries of <29 week gestation babies occur at a true "Level III" perinatal center, Arkansas anticipates reducing infant deaths by about 20 per year.

Use of 17-hydroxyprogesterone for women with a history of preterm delivery is increasing. Use of progesterone vaginal gel for a "thin" cervix is awaiting national consensus of MFM specialists but appears to be the first significant breakthrough in the long search for a practical prevention of preterm deliveries.

c. Plan for the Coming Year
The ADH Family Health Branch will:

-Continue collaboration with all involved groups working toward development and implementation of NICU designations and perinatal regionalization

-Pursue alternative strategies to improve rates of very low birth weight delivery in Level III equivalent perinatal/neonatal facilities, including provider education and discussion of possible incentive strategies with Arkansas Medicaid

-Continue to work with UAMS MFM to investigate future implementation of programs to reduce preterm deliveries

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	81	82	82	82	82
Annual Indicator	76.4	76.4	75.8	77.2	78.5
Numerator	31602	31450	30130	29793	29814
Denominator	41380	41168	39730	38578	37981
Data Source		2008 Birth Certificates	2009 Birth Certificates	2010 Birth Certificates	2011 Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or				Provisional	Provisional

Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	82	82	82	82	82

Notes - 2011
2011 indicator represent data from Federal Fiscal Year 2011.

Notes - 2010
2010 indicator represent data from Federal Fiscal Year 2010.

Notes - 2009
2009 indicator represent data from Federal Fiscal Year 2009.

a. Last Year's Accomplishments
The Department of Health continued to provide pregnancy testing through family planning clinics in local health units statewide. Women seeking pregnancy or with positive pregnancy tests received information on the importance of early and adequate prenatal care. The ADH Health Connections Section continued to assist pregnant Medicaid recipients in accessing health care providers and other health resources in their community.

A total of 4,871 pregnant women were served in ADH prenatal clinics in 2011. Six ADH maternity clinic sites were added since last year's report, bringing the total to 61 statewide. Of all the women seen through ADH for maternity services in CY11, 57% had their initial visit during the first trimester. ADH served many pregnant women who lacked Medicaid or private insurance upon presentation. Presumptive eligibility for pregnant women allowed them to receive prenatal services while their Medicaid applications were pending.

At the local level, Hometown Health Initiative (HHI) Coalitions provided education to women on multiple topics each month, including the need for early prenatal care. The ADH Maternal Infant Program, which operates home visiting services in nearly every county in the state, provided yet another avenue for encouraging women to seek care early in pregnancy. Finally, the WIC program included an inquiry on initiation of prenatal care during patient certification, followed up as needed with a referral and/or assistance in applying for Medicaid presumptive eligibility.

Maternal and Infant Early Childhood Home Visiting (MIECHV) grant funds awarded in 2011 allowed establishment of Nurse-Family Partnership (NFP) services in six counties - Monroe, Mississippi, Lee, Phillips, Crittenden, and St. Francis. The NFP model recruits women during pregnancy and emphasizes early and complete prenatal care. Funds were also received under a MIECHV expansion grant that allowed additional mothers and children to be served under the Parents as Teachers and Healthy Families America models, extending their reach into 27 and 18 counties, respectively. Pregnant women served under these latter two models also receive encouragement to obtain early prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Pregnancy tests were provided through local health units upon request	X			
2. Information and referrals were provided to women with positive pregnancy tests		X		
3. Presumptive eligibility for Medicaid was afforded those with no coverage while their applications were pending		X		

4. Health Connections assisted pregnant women in finding appropriate care providers		X		
5. 4,871 pregnant women were served in 61 ADH Maternity Clinic sites around the state	X			
6. Hometown Health Initiative Coalitions educated local women on the need for early prenatal care		X		
7. The WIC program inquired about prenatal care initiation upon certification of pregnant women and offered referrals/assistance as needed		X		
8. MIECHV home visiting services were established in a number of new counties, which encouraged pregnant participants to receive early prenatal care		X		
9.				
10.				

b. Current Activities

ADH direct maternity care services are now provided in 61 local health units in 55 counties. ADH provides the initial prenatal visit to an average of 5,100 women annually. There is variability across the state in the length of time the patient continues to receive prenatal services from ADH. The approval for Medicaid is the primary reason the patient moves to a private provider. Combining all visits (initial and subsequent) and dividing by the number of initial prenatal visits, the average number of prenatal visits for an ADH maternity patient is 2.78. The women who remain under care with ADH benefit from the contracted and collaborated services between ADH and the UAMS Department of OB/GYN. ADH through an interagency contract with UAMS OB/GYN provides High Risk Prenatal Care to patients via telephone and telemedicine consultations through the telemedicine units provided by UAMS in many LHU's.

Nurse-Family Partnership home visiting activities are currently being expanded to Jefferson County. MIECHV expansion grant funds are being used to extend the reach of four other home visiting models in the state. All of the models that enroll pregnant women encourage early and consistent prenatal care.

c. Plan for the Coming Year

ADH will continue to offer pregnancy testing to women through local health units, with education and referrals for those who test positive. Presumptive eligibility services will be sustained as well. The Health Connections Section (ConnectCare Program) will continue to assist pregnant Medicaid recipients in finding appropriate care providers.

As always, ADH maternity services will continue to be targeted to communities of greatest need.

ADH and UAMS/ANGELS will continue to expand on existing collaborations as well as to find exciting new ways to provide high-risk prenatal and gynecological care to the state's most vulnerable women. UAMS/ANGELS telemedicine conferences enable ADH Clinicians to confer with maternal-fetal medicine specialists in real-time about individual cases which includes high risk obstetric consults for ADH patients. Clinical telemedicine consultations are available that allow ADH patients, ADH Clinicians, and UAMS physicians to talk together and see each other. These services will be expanded in coming years.

MIECHV home visiting activities will continue to expand, helping promote early and comprehensive prenatal care for all pregnant participants.

D. State Performance Measures

State Performance Measure 1: *Rate of births per 1,000 for teenagers aged 18 through 19 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					93.5
Annual Indicator			102.3	90.7	82.2
Numerator			4049	3762	3409
Denominator			39571	41497	41497
Data Source			Birth Certificates, US Census Bureau	2010 Birth Certificates, US Census Bureau	2011 Birth Certificates, US Census Bureau
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	78	76	74	72

Notes - 2011
Data source: 2011 Birth certificate data; 2010 Population estimates, US Census Bureau.

2010 Population estimate used to calculate 2011 indicator.

Notes - 2010
Data source: 2010 Birth certificate data; 2009 Population estimates, US Census Bureau.

2009 Population estimate used to calculate 2010 indicator.

Notes - 2009
Data source: 2009 Birth certificate data; 2009 Population estimates, US Census Bureau.

a. Last Year's Accomplishments
Last year saw the start of the activities funded through the PREP Grant. The funds are being used to sponsor a program for teen pregnancy prevention and life skills training for Foster Care Children in Central Arkansas. This has had a very slow start. Gaining the cooperation of Foster Care Teens for participation in the program has been much harder to obtain than estimated. Participation has been low. Changes are being pursued with case managers and court officials that should result in greater participation.

New abstinence Education efforts have been established in multiple locations around the state, mostly targeted to middle and high school-aged students.

Another new activity was the establishment of the Teen Pregnancy Prevention Action Group under the Natural Wonders Partnership. This group is made up of stakeholders who wish to look for opportunities and synergies in actions that will reduce the number of unintended teen pregnancies in the state. The group meets monthly and is developing an action plan.

Outreach activities through the local health units to bring teens into the family planning clinics have continued. A total of 9,170 teens 18 and 19 years of age utilized the Title X Family Planning clinics at the Arkansas Dept. of Health in 2011. Priority for appointments and access are given to teens.

A new satellite family planning clinic was established as a community college in Northeast Arkansas.

Usage rates of longer acting contraceptive methods supplied through ADH increased somewhat for 18-19 year olds in 2011. Thirty-one percent of young women this age received DepoProvera as a primary method in 2011, compared to 26% in 2010.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Outreach activities continued through the Title X Family Planning clinics at the Arkansas Dept. of Health local health units to bring teens into the family planning clinics.		X		
2. The Teen Pregnancy Prevention Action Group under the Natural Wonders Partnership was established.				X
3. New Abstinence Education efforts were carried out statewide.		X		
4. The PREP grant was utilized to create a program for teen pregnancy prevention and life skills training for foster care children in Central Arkansas.		X		
5. A satellite family planning clinic was established at a community college in NE Arkansas				X
6. A total of 9,170 18-19 year olds were served through ADH family planning clinics.	X			
7.				
8.				
9.				
10.				

b. Current Activities

The activities described for last years accomplishments have continued into the present. The Teen Pregnancy Prevention Action Group continues to mature and grow. ADH local health units continue local outreach efforts to educate teens on the availability of family planning services. Abstinence Education continues in multiple locations around the state. Unfortunately, Arkansas still has one of the highest rates of birth for 18 and 19 year olds in the nation.

c. Plan for the Coming Year

Efforts will continue for the PREP Grant activities for foster care teens or teens transitioning out, in central Arkansas as well as the abstinence education activities around the state. The Teen Pregnancy Prevention Action Group will be considering advocacy for policy change and further development of teen pregnancy prevention activities around the state.

State Performance Measure 2: *Percentage of women aged 18-44 years who report being current smokers.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective	**2007**	**2008**	**2009**	**2010**	**2011**

and Performance Data					
Annual Performance Objective					20
Annual Indicator			20.4	21.9	24.5
Numerator					
Denominator					
Data Source			2008 Behavioral Risk Factor Surveillance System	2009 Behavioral Risk Factor Surveillance System	2010 Behavioral Risk Factor Surveillance System
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	22.7	22.3	21.8	21.4	20.5

Notes - 2011
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

Weighted denominator and numerator not available.

2010 data used for 2011 indicator.

Notes - 2010
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

Weighted denominator and numerator not available.

2009 data used for 2010 indicator.

Notes - 2009
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

Weighted denominator and numerator not available.

2008 data used for 2009 indicator.

a. Last Year's Accomplishments
The Arkansas Department of Health continued to operate the Arkansas Tobacco Quitline, accessible through phone, fax or telephone referral. In FY2011, over 13,000 Arkansas Tobacco users enrolled to use the Quitline. The Quitline received multiple referrals from ADH local health units. For CY2011, the ADH Encounter Management System reported 22,270 encounters (duplicate patients) on smoking cessation education and 3,491 referrals (unduplicated patients) to the Quitline. Referrals for family planning clients accounted for 90% of the referrals.

The Arkansas Tobacco Quitline remained available seven days a week, 24 hours a day. Services were available in English, Spanish and additional languages as needed, including Marshallese. The ADH website header included a quick link to information on the Quitline and provided

enrollment online and a link to "Speak to a Quit Coach now." Participants have unlimited access to Web Coach™, an interactive online community that offers tools to quit, social support, and information about quitting.

ADH policies and procedures, as well as the ADH Nurse Practitioners' (NP) protocols, included education and counseling standards on smoking cessation. Patients seen in local health units were assessed for tobacco use and offered education and referral to the Quitline. ADH NPs were allowed by protocol to prescribe nicotine replacement medications as indicated.

The Tobacco Prevention and Cessation Program's (TPCP) Master Settlement Act budgets for FY10 and FY11 were $22 and $19 million respectively, plus $1 million in CDC funding in each year. These funds have been vital in supporting extensive smoking cessation programs across the state. TPCP works with local Hometown Health Initiative coalitions to implement smoking cessation programs and practices in their communities. Examples of these efforts last year included posting of smoke-free park areas in Union County, sponsoring essay contests on "Stamp out Smoking" for students in elementary and middle schools, collaborating with medical providers in Boone County to recruit and refer pregnant women to the Quitline, hosting a national speaker in Clark County to speak to teens on spit tobacco and smoking cessation, and addressing smoking prevention at a town hall meeting in Franklin County that included over 250 attendees. In all, TPCP funded 19 different community programs impacting 34 counties last year.

TPCP also supported the implementation of evidence-based practices through a wide network of partners that included colleges, community-based organizations, corporations, health care providers, hospitals, law enforcement agencies, local health units, media companies, nonprofits, and other state agencies. The TPCP collaborated with the Arkansas Department of Education to support the CDC model of Coordinated School Health (CSH). CSH successes last year included providing tobacco education activities to over 11,000 students. Policy interventions included Arkansas Act 811 of 2011, which made it a primary offense to smoke in a vehicle with children under age 14 present, and implementation of the Arkansas Clean Air on Campus Act which compelled all state-funded colleges and universities to go smoke-free in late 2010.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. ADH policies called for assessment of tobacco use of all women seen for services in local health units				X
2. Smoking cessation education was provided to ADH clients in local health units		X		
3. Over 3,000 ADH Family Planning clients were referred to the Arkansas Tobacco Quitline		X		
4. The Arkansas Tobacco Quitline operated 24/7, with services available in multiple languages and online services available as well			X	
5. ADH nurse practitioners provided prescriptions for nicotine replacement medications as indicated	X			
6. The Tobacco Prevention and Cessation Program worked in conjunction with Hometown Health coalitions to foster smoke-free communities through education and policy change		X		X
7. TPCP worked with Coordinated School Health schools to deliver tobacco prevention messages to over 11,000 students		X		
8. Act 811 of 2011 made it illegal to smoke in a vehicle with children under the age of 14 present				X
9.				

10.				

b. Current Activities
ADH continues strategic plans to prevent and reduce tobacco use through TPCP funds. The support of the Coordinated School Health program has and will continue to generate collaboration between schools and communities to ensure children receive the education needed to stay healthy and tobacco-free. Hometown Health Initiative (HHI) coalitions encourage their communities and coalitions to focus on tobacco prevention and cessation, which results in ongoing events and outreach efforts on the need for a tobacco-free community. These activities include promoting use of the Quitline, educating community members about the benefits of smoke-free parks and workplaces, and informing key stakeholders such as city councils.

Patients seen through family planning and other ADH clinic services continue to be assessed for tobacco use and counseled/referred as needed. ADH nurse practitioners continue to prescribe nicotine replacement medications as indicated.

c. Plan for the Coming Year
This state measure will be continued.

Through the CSH program's collaborative efforts with the schools and communities, the facilitation of programs which include tobacco prevention education, comprehensive school based tobacco policies and promotion of tobacco cessation for staff and students will continue. By 2014, the number of school districts implementing comprehensive evidence-based interventions recommended by the CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction, including policies and curriculum, will increase to 10 percent of all school districts. ADH TPCP will continue to support coalitions, colleges, community-based organizations, corporations, health care providers, hospitals, law enforcement agencies, local health units, media companies, nonprofits, and other state agencies in their efforts toward tobacco prevention and cessation. ADH will continue to support strong enforcement of laws regarding Arkansas tobacco manufacturers, wholesalers and retailers. ADH will also strive to increase the number of Quitline enrollments and to offer up to ten one-on-one counseling sessions for pregnant women compared to the five sessions for the other callers. The Hometown Health Initiative will continue to encourage their communities and coalitions to focus on tobacco prevention and cessation. ADH programs, Family Planning, Maternity, WIC, STD and BreastCare will continue to screen all patients for tobacco use and provide counseling, education and referrals to the Quitline.

State Performance Measure 3: *Proportion of children aged 0-14 years with Injury Severity Score (ISS) of greater than 15 who receive definitive treatment in a Level I pediatric trauma center.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					72
Annual Indicator				68.8	90.5
Numerator				33	57
Denominator				48	63
Data Source				Hospital Discharge Data System	Hospital Discharge Data System
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	92	93	94	94	95

Notes - 2011
Data source: 2010 Hospital Discharge Data System.
2010 is latest available data.

Notes - 2010
Data source: 2009 Hospital Discharge Data System.
2009 is latest available data.

a. Last Year's Accomplishments
Since last year's report, exponential progress has occurred with respect to development of the state trauma system established through legislation passed in 2009. Remarkably, 40 hospitals have been designated in the past year alone, bringing the state total to 50. Although the Trauma Section within the ADH Injury Prevention and Control Branch bears chief responsibility for making the system work, their efforts have been greatly aided by the Governor's Trauma Advisory Council. Comprising a diverse partnership of trauma surgeons, hospital CEO's, emergency medical services representatives, injury prevention advocates, other health providers, and consumers, the council has continued to provide leadership through work of six very active subcommittees.

Specifically related to children, in the past year an out-of-state pediatric hospital, LeBonheur Children's in Memphis, has been added to the system as an acceptable Level 1 facility for treatment of severely injured Arkansas children less than 15 years old. Transports to this facility occur chiefly from parts of Eastern Arkansas that are closer to Memphis than Little Rock.

Another innovation relative to children in the past year is the Trauma Image Registry. Several participating hospitals in the trauma network have begun transmissions of computed tomography images over the internet to specialists at Arkansas Children's Hospital (ACH) prior to transport, giving doctors there more detailed information needed to prepare for the child's treatment and also eliminating the need for repeat scanning once the child arrives at ACH.

The trauma "dashboard" system has been enhanced during the past year. Every participating hospital employs web-based software to maintain an up-to-the-minute status report of available medical/surgical staffing, open emergency department beds/rooms, and open operating rooms. This information is monitored and utilized by staff in the central Call Center in Little Rock. When contacted by field EMS staff or local hospitals handling a moderate to severe trauma case, a nurse or EMT housed in the Call Center makes a decision about the appropriate facility to which the patient should be transported. As reported last year, the average time from an initial call to determination and acceptance by a receiving hospital has been cut to about 7 minutes.

Data system enhancements in the past year include provision of routine reports back to participating hospitals for quality improvement purposes. Proprietary web-based software is utilized for this to-and-fro exchange of information.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. An additional 40 hospitals were designated part of the state trauma system				X
2. LeBonheur Children's in Memphis was designated a Level 1 pediatric trauma center within the Arkansas trauma network				X

3. The 24/7 staffed Call Center for statewide trauma care coordination was enhanced				X
4. The Trauma Image Registry allowed for internet transmission of computed tomography scans to specialists at Arkansas Children's Hospital prior to patient transport				X
5. Quality improvement efforts were enhanced through transmission of data reports back to participating hospitals				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
An additional five hospitals are in the process of receiving trauma system designation.

The Governor's Trauma Advisory Council and its six subcommittees continue to meet monthly.

A pediatric surgeon with a keen interest in serving children continues to serve as the medical consultant to the ADH Trauma Section.

The process of revising the rules and regulations pertaining to trauma care has recently been initiated. Newer recommendations by the American College of Surgeons will be incorporated into the new regulations.

c. Plan for the Coming Year
This state measure will be continued.

The additional 5 hospitals should be designated by later in 2012. Virtually all of the Level 1 and Level 2 hospitals have been designated along with most of the Level 3's, leaving only a few Level 4 designations yet to be done.

The revisions to the rules and regulations will hopefully be completed and approved within the next year or shortly thereafter.

The Trauma section is planning additional outreach to participating hospitals in efforts to tighten procedures and close gaps in the system. Hospital staff will be apprised of how changes to the rules and regulations will affect their daily trauma operations.

Additional outreach and further training of pre-hospital emergency providers is also planned by the Trauma Section.

State Performance Measure 4: *Percentage of people on community water systems whose water is appropriately fluoridated.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					75
Annual Indicator				65.0	64.7
Numerator				1732962	1724131
Denominator				2666839	2666306

Data Source				CDC Water Fluoridation Reporting System	CDC Water Fluoridation Reporting System
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	71	77	82	87	88

a. Last Year's Accomplishments
In August of 2010, the Office of Oral Health convened partners and stakeholders in the CDC/CDHP Oral Health Policy Tool workshop. The facilitated workshop provided an opportunity to set policy priorities for oral health in Arkansas. The top priority selected during the process was to increase the percentage of Arkansans on water systems that receive the benefits of water fluoridation. Based on that workshop, State Senator David Johnson filed legislation to require fluoridation for all water systems that serve 5000 or more customers. The legislation passed in March of 2011 and was signed by Governor Beebe as Act 197 of 2011. The Act provides that systems do not have to comply until funds from non-tax sources are available. The Delta Dental of Arkansas Foundation pledged up to $2,000,000 to provide for equipment and start-up costs for new fluoridating systems. Successful fluoridation of those systems will bring the fluoridation rate in Arkansas to 87%. In addition, the Foundation pledged funding for all appropriate water systems below the 5000 threshold which could bring the fluoridation rate to almost 90%.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Office of Oral Health convened a CDC/CDHP Oral Health Policy Tool workshop which set increased fluoridation as a priority				X
2. Act 197 of 2011 was passed, requiring community water systems serving more than 5,000 customers to be fluoridated				X
3. The Delta Dental of Arkansas Foundation pledged up to $2,000,000 to assist affected water systems in complying with Act 197				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Delta Dental of Arkansas Foundation has released grant applications to community water systems and hopes to provide the necessary equipment for the 32 affected systems by 2013. The Office of Oral Health is working closely with the Foundation to help prioritize systems for fluoridation.

c. Plan for the Coming Year
This state measure will be continued.

Now that the much anticipated fluoridation legislation has passed, the Office of Oral Health and the Family Health Branch will monitor for compliance by community water systems. The Office of

Oral Health will continue to work with smaller systems to encourage them to voluntarily fluoridate, particularly since the Foundation also offers funding support to help them do so.

State Performance Measure 5: *Percentage of school-aged children with body mass index greater than the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					37.5
Annual Indicator				38.1	38.3
Numerator				67891	68455
Denominator				178015	178873
Data Source				Arkansas Center for Health Improvement	Arkansas Center for Health Improvement
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	37	36.5	36	35.5	35

Notes - 2011
Data Source: Arkansas Center for Health Improvement, Year Eight Assessment of Childhood Obesity in Arkansas (Fall 2010-Spring 2011), Little Rock, AR: ACHI, January, 2012.

Notes - 2010
Data Source: Arkansas Center for Health Improvement, Year Seven Assessment of Childhood Obesity in Arkansas (Fall 2009-Spring 2010), Little Rock, AR: ACHI, December 2010.

a. Last Year's Accomplishments
Act 1220 of 2003, Arkansas's centerpiece legislation targeting childhood obesity, continued to be assessed in the past year. Act 1220 prescribed a number of measures, including formation of the Child Health Advisory Committee (tasked with making recommendations to the Department of Education-ADE and Board of Health), mandatory BMI measurements for public school students, prohibition of vending machine access by elementary school students, creation of nutrition and physical activity advisory committees in all school districts, and requirements for school districts to disclose expenditures and receipts related to competitive food and beverage contracts. The UAMS College of Public Health has performed an ongoing evaluation of Act 1220 outcomes. Results for Year 7 (2010) showed that 66% of schools had policies forbidding sale of junk foods in vending machines (compared to 18% in 2004). In Year 8 (2011), only 48% of students reported even having access to a beverage vending machine at school (compared to 97% in 2004). In 2011, 50% of students reported making no recent beverage machine purchases at school, compared to 22% in 2004.

The Child Health Advisory Committee (CHAC) continued to meet monthly to discuss the need for new anti-obesity approaches. In 2011 the recommendations to ADE that had been drafted in 2009 were again revised and presented to ADE for consideration. These included wide-ranging guidelines on nutrition practices, physical activity, health, and social services/mental health. The CHAC also met with ADE officials to discuss proposed changes to ADE rules and regulations pertaining to physical education and activity which threatened to relax previously enacted standards for certified physical education teachers and teacher:student ratios for PE in elementary schools. As a result of these discussions, a compromise was reached on the wording of the regulations.

Body mass index (BMI) measurements continued to be collected on public school students in kindergarten, second, fourth, sixth, eighth, and tenth grades. These data were transmitted to the Arkansas Center for Health Improvement (ACHI), which analyzed them and compiled them into an annual report. The percentage of overweight and obese children shown above (38.3%) is very consistent with data from the last several years. ACHI also housed the national Robert Wood Johnson Foundation Center to Prevent Childhood Obesity, created in 2009 with a $20 million grant from RWJ. The center worked to bring together the best available evidence on childhood obesity, to educate decision-makers on most effective policies, to develop capacity and leadership, and to put forth effective communication strategies to make needed policy changes. Unfortunately, the center closed in November 2011.

The Fresh Fruit and Vegetable Program conducted through the Department of Education continued to expand last year. During the 2010-11 school year, 77 schools representing 31,055 students participated. The program provided students with fresh produce throughout the school day in an effort to inform and promote healthier dietary choices.

The Arkansas Tobacco Settlement Commission funded 59 schools for the Child Wellness Intervention Project (CWIP) during the 2010-11 school year. Participating schools agreed to utilize proven curricula and assessments including SPARK, PE4Life, Fitnessgram, and HealthTeacher.com. Virtually all of the Coordinated School Health schools participated in the CWIP initiative. Tobacco settlement funds also continued to support Community Health Promotion Specialists (CHPs) in each public health region of the state. CHPs worked in schools (in conjunction with educational cooperatives) and with community organizations (particularly Hometown Health Improvement coalitions) to promote messages around healthy eating and physical activity.

The Arkansas Coalition for Obesity Prevention (ArCOP), with 230 people representing over 60 agencies, continued its Growing Healthy Communities project to support healthy living for individuals and communities. This project, which involves collaboration between ArCOP, ADH, UAMS, the Winthrop Rockefeller Institute, and others, emphasizes policy change at the local level. The five community groups receiving awards in 2011 were the Jones Center, City of Nashville, Van Buren Co. TEA, UALR Dept. of Health Sciences, and Desha HHI.

Act 855 was also passed in 2011 requiring health insurers to cover treatment of morbid obesity.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Year 8 evaluation of Act 1220 of 2003 showed that schools had significantly more policies forbidding junk food sales and students had reductions in vending machine purchases and access while at school, compared to 2004				X
2. The Child Health Advisory Committee (CHAC) presented recommendations to the Dept. of Education (ADE) on a variety of nutritional and physical activity topics				X
3. The CHAC met with ADE to discuss revised wording of standards for physical education for elementary students				X
4. Body mass index (BMI) measurements continued to be collected regularly in schools and reported to parents			X	
5. The Arkansas Center for Health Improvement analyzed school BMI data and continued to operate the RWJ-funded Center to Prevent Childhood Obesity				X
6. A total of 65 schools participated in the Child Wellness		X		

Intervention Project in the 2010-11 school year, utilizing national models and curricula				
7. The Fresh Fruit and Vegetable Program continued to expand its reach, serving over 31,000 students in the 2010-11 school year and over 43,000 in the 2011-12 school year			X	
8. The Arkansas Coalition for Obesity Prevention funded an additional 5 communities to establish Growing Healthy Communities projects				X
9. ADH Community Health Promotion Specialists continued to provide obesity prevention information in schools		X		
10. Act 855 was passed, requiring health insurers in the state to cover treatment of morbid obesity.				X

b. Current Activities
The Child Health Advisory Committee (CHAC) continues to meet monthly to consider new recommendations for education and public health regarding obesity prevention and other health issues. A response from the Department of Education on the last major set of recommendations issued is still pending.

BMI measurements continue to be collected on public school students in even grades, K-10.

The Fresh Fruit and Vegetable Program has again expanded, with current year funding of $2.3 million. In this school year (2011-12), 115 schools are participating, representing 43,259 students potentially reached. Proposals for the 2012-2013 school year are being reviewed.

The Arkansas Coalition for Obesity Prevention (ArCOP) continues its Growing Healthy Communities (GHC) initiative which currently involves 22 communities. Participating communities are required to have measurable objectives related to increased access to healthy and affordable foods and increased access to physical activity. Local GHC teams must include city government leadership including mayors, city council members, planning commissioners, parks directors, etc. ArCOP has recently convened 3 immersion trainings to provide technical assistance, resources, networking, and program planning to the sites. GHC applications for the coming year are now being accepted from additional communities.

A total of 64 CWIP grants serve schools ranging from pre-K to middle school in the current (2011-12) school year.

c. Plan for the Coming Year
This state measure will be continued.

CHAC activities will continue as mandated under Act 1220 of 2003.

Mandatory BMI measurements in schools will continue, with analysis through ACHI.

The Fresh Fruit and Vegetable program will receive federal funding for the 2012-2013 school year sufficient to serve approximately 110 schools representing 45,400 students.

ArCOP's Growing Health Communities initiative is expected to increase in scope in the coming year. ArCOP is planning to conduct topic-specific training for participating communities in areas such as developing/expanding farmers' markets, Complete Streets for Active Transportation, Walking Audits, and coalition-building for action, among others. These trainings will focus on the significant accomplishments of established GHC sites as a way to mentor newly added communities. Trainings are planned for each of the 5 public health regions in the state, thereby increasing visibility and awareness of the process among other candidate communities as well.

Tobacco settlement funding of CWIP activities in schools is expected to continue. Coordinated School Health schools will continue to participate prominently in these activities.

Family Health and other ADH staff will continue to weigh in on child obesity prevention efforts through participation on CHAC, ArCOP, and Coordinated School Health activities, and through ongoing efforts by regional Community Health Promotion Specialists.

State Performance Measure 6: *Percentage of respondents indicating Title V CSHCN program personnel have communicated information on one or more program(s)or service(s)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					55
Annual Indicator			52.7	52.7	66.2
Numerator			59	59	229
Denominator			112	112	346
Data Source			Needs Assessment Survey	Needs Assessment Survey	AR CSHCN Annual Survey of Families 2012
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	68	72	75	78	80

Notes - 2010
A new survey eliciting this specific information was not done in 2010.

a. Last Year's Accomplishments
An online screening tool for Title V CSHCN program via Access AR tool on the Department's website remains in place for public use.

CSHCN staff provided updated information for the Division's website during 3 Division meetings with the Division of Systems & Technology.

CSHCN staff developed online information on the Autism Family Support Grant (AFSG) for the Division's website and provided official responses for FAQ on the AFSG for autism advocacy group's blog and assisted families of 858 CSHCN diagnosed with ASD in the application process and eligibility determination for the Grant.

CSHCN staff provided referral and intake for 1,072 individuals applying for the DDS Home and Community-based waiver and 47 individuals applying for the DDS Special Needs programs.

CSHCN staff referred families of 266 CSHCN for Title V Family Support/Respite completing eligibility review and processing awards.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Met with the Division's Information System's Manager over the past year to prioritize programs' system.				X
2. Referrals to other agency's programs to assist families in obtaining services for CYSHCN.		X		
3. Regional Managers complete random record reviews of active cases to assure that referrals are being made appropriately to other programs.				X
4. CSHCN staff made requests for funding from Title V CSHCN program for services not covered by other programs such as compound drugs, certain durable medical equipment, wheelchair ramps to home, wheelchair lifts for vans, and overhead lifts for home.		X		
5. CSHCN staff referred to the Title V Family Support/Respite program to assist families in purchase of eligible goods/services needed by the CSHCN but not provided by other programs.		X		
6. CSHCN staff referred individuals diagnosed with ASD to the Autism Family Support Grant.		X		
7. CSHCN staff developed and mailed a quarterly newsletter that shares information on parent support groups statewide, legislative issues, and program information.		X		
8.				
9.				
10.				

b. Current Activities

Title V survey had 2 questions related to information on this performance measure. 66% said that in the last 12 months Title V staff shared information about other services for the child. 71% said Title V staff had contacted them within the past 6 months.

Staff establish priority for information system needs, such as update of the Title V webpage, development of a new data system due to anticipated retirement of the mainframe system and movement toward electronic records.

Title V staff make referrals to other programs, such as Child & Adolescent Service System Program & System of Care for children/youth with serious emotional disturbance; DDS Waiver; ICF admission; Special Needs & Integrated Supports for individuals with developmental disabilities; the Autism Family Support Grant; SSI & TEFRA for coverage of medical care.

Regional Managers complete random audits of active cases to assure that referrals are being made appropriately.

Title V staff make requests for funding from Title V for services not covered by Medicaid such as compound drugs, certain durable medical equipment, wheelchair ramps to home, wheelchair lifts for vans, and overhead lifts for home.

Staff refer to the Title V Family Support/Respite program to assist families in purchase of eligible goods/services needed by the CSHCN but not provided by other programs.

Staff sends a quarterly newsletter that shares information on parent support group meetings, legislative issues, and program information.

c. Plan for the Coming Year

CSHCN staff will continue to work with individual families to make them aware of resources available; assist in completion of applications for services and make referrals for other programs that can provide the family with assistance that they may need.

Continue upgrade of the program's information system and website to enable access to program information, local contacts for the program, access to online referral information and access to the program newsletter. Work on the webpage is needed to provide current information on programs & staff. Program needs related to this effort have been discussed with the Division's Information System's Manager.

CSHCN staff will develop a survey instrument for mailing and an online version to elicit information from consumers.

State Performance Measure 7: *Percentage of CSHCN care coordination staff expressing unmet needs related to workforce development and/or training*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					20
Annual Indicator			23.8	25.0	53.6
Numerator			10	9	15
Denominator			42	36	28
Data Source			Needs Assessment survey	Needs Assessment	Employee Survey
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	45	40	35	30

Notes - 2011
The Employee Survey for 2012 was revised to attempt to gather more meaningful information. This year, of 28 respondents, all 28 indicated Yes when asked Has job related training been offered to you in the past year? The question on the survey from which this years' data comes is: What type of training needs do you currently have? Of the 28 respondents, 15 listed training that they felt would be helpful to them. Although the data has changed dramatically, we feel this change will lead to more effective outcomes.

Notes - 2010
These figures are from an Employee Survey question that asked: Has job related training been offered to you in the past year? 9 of 36 employees answered either strongly disagree or disagree.

a. Last Year's Accomplishments
Self or supervisory referral to Departmental training sessions to improve employee skill levels in use of computer software packages, business writing, interpersonal communication, and other topics dealing with the workplace environment.

CSHCN Nurses and Social Workers participated in neonatal and pediatric sessions offered by the University of AR for Medical Sciences ONE Team nursing continuing education weekly

teleconferences. Topics focused on obstetrical, neonatal and pediatric nursing, evidence-based practices and current standards for patient care.

The AR LEND program provides opportunities for Title V CSHCN staff to receive training offered by teleconference to LEND students.

All CSHCN Nurses and Social Workers were offered the opportunity to attend the Team Up 2011 Autism conference which focused on evidence based interventions for children with autism.

CSHCN staff members were offered the opportunity to attend training offered by the AR State Employees Association and the AR Human Services Employees Association. These conferences offered sessions on personal development, workplace issues, and dealing with consumers with diagnosis specific conditions.

CSHCN medical records staff attended state conference required for continuing licensure which provided training on electronic medical records management, HIPAA.

Conducted an online survey of staff related to training needs, supervisory support and job satisfaction.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Self or supervisory referral to Departmental training sessions to improve employee skill levels in use of computer software packages, business writing, interpersonal communication, and other topics dealing with the workplace environment.				X
2. CSHCN Nurses and Social Workers participated in neonatal and pediatric sessions offered by the University of AR for Medical Sciences ONE Team nursing continuing education weekly teleconferences.				X
3. CSHCN staff members were offered the opportunity to attend training offered by the AR State Employees Association and the AR Human Services Employees Association.				X
4. CSHCN medical records staff attended state conference required for continuing licensure which provided training on electronic medical records management, HIPAA.				X
5. Through the CoBalt initiative for screening and evaluation for Autism, several local CSHCN caseworkers were provided diagnosis specific training to assist in care coordination.				X
6. Two days of training were provided to all professional and clerical staff that work directly with families. Information was provided on the issue of transition and training was given on new electronic processes being adopted by the program.				X
7. Surveyed employees regarding training needs.				X
8.				
9.				
10.				

b. Current Activities

Departmental training sessions to improve employee skill levels in use of computer software packages, business writing, interpersonal communication, and other topics dealing with the workplace environment continue.

CSHCN Nurses and Social Workers continue to participate in neonatal and pediatric teleconference sessions offered by the University of AR for Medical Sciences.

Through the CoBalt initiative for screening and evaluation for Autism, several local CSHCN caseworkers were recently provided diagnosis-specific training to assist in care coordination.

Two days of training were provided to all professional and clerical staff that work directly with families.
Information was provided on the issue of transition and training was given on new electronic processes being adopted by the program.

c. Plan for the Coming Year
Offer more small group training on issues identified by employees.
Continue offering training in the Departmental, UAMS, and LEND venues.
Develop opportunities for clerical staff to improve skills.
Investigate the ability to develop online program specific training tools.
Develop procedures and provide training for move to electronic program records.
Update/upgrade procedure manual.

E. Health Status Indicators

Health status indicators (HSI's) track a number of health outcomes as well as a number of demographic analyses and assessments of social service utilization. Priorities within ADH include infant mortality reduction, injury prevention, and infectious disease prevention. Within the Family Health Branch, childhood fatality and poverty also stand out as key indicators. The following discussion highlights HSI's related to these priorities.

Birth rates for low birth weight (<2500 gms; HSI #01) have declined slightly over the past several years. Prevention of preterm labor has traditionally been an elusive goal, but newer strategies such as prenatal 17-hydroxyprogesterone administration to high-risk women hold promise. Although at present only approved for use in women with previous preterm births, 17OHP has the potential to prevent about 8% of all premature deliveries. Costs of brand-name 17OHP are prohibitive, which has served as an additional barrier to its use by obstetricians. The state Medicaid program in Arkansas has recently been working with pharmacies in the state to identify some that are willing to compound the product at a lower cost.

Immunization of pregnant women against influenza has been shown to be of benefit in preventing preterm deliveries during flu season. ADH local health units are aware of recommendations for flu vaccine during pregnancy and promote immunization aggressively for pregnant patients seen in Maternity and WIC clinics. The Family Health Branch recently sent a survey to all delivering physicians in the state to assess attitudes and practices toward influenza vaccination of pregnant women; results have not yet been fully analyzed.

Prevention of elective delivery of women prior to 39 weeks gestation must also be pursued aggressively to prevent unnecessary infant morbidity. In Arkansas, the state March of Dimes (MOD) chapter is approaching hospital delivery services with their "Healthy Babies are Worth the Wait" campaign materials. ADH has also partnered with MOD and the state American Congress of Obstetricians and Gynecologists (ACOG) chapter to inform all physicians in the state who deliver babies about the need to refrain from elective inductions and C-sections prior to 39 weeks.

Smoking during pregnancy also adversely impacts birth weight. The Tobacco Prevention and Cessation Program has an ongoing pilot to incentivize smoking women to quit. Accelerating cash rewards are offered to participants for every visit they demonstrate negative urinary cotinine levels, up to a total of approximately $1,000. The program is currently being expanded from two sites in the state to include several more. Evaluation of effectiveness is ongoing.

Births of infants less than 1500 grams (HSI #02) have only minimally decreased in the last five years. To prevent this birth weight outcome, again 17-hydroxyprogesterone shows promise but to date has not been utilized to its full potential in Arkansas. Early and regular prenatal care has always been a logical recommendation in this regard, but studies have failed to document its efficacy in preventing preterm labor. Therefore, for now emphasis must remain on appropriate care of infants born this small. An initiative is underway in Arkansas to designate levels of care for hospital nurseries and to consider a system of regionalized perinatal/neonatal care. Remarkably, Arkansas is one of a handful of states that has never officially sanctioned levels of hospital neonatal or perinatal care. The need to accomplish this task in Arkansas is reinforced by a 2010 meta-analysis by Lasswell et al showing much better outcomes for infants weighing less than 1500 grams at birth who deliver in tertiary care perinatal/neonatal centers. A working group has been formed by the ADH Director in conjunction with the Arkansas Hospital Association consisting of representatives of local hospitals, neonatologists, pediatricians, obstetricians, MOD, the Arkansas Medical Society, and other interested groups to make recommendations back to ADH. The group's recommendations should be completed by the fall of 2012 and will incorporate new neonatal care guidelines currently under development at the national level by the American Academy of Pediatrics.

Moving on to older children, fatal injuries to Arkansas children (HSI #03) have historically occurred at much higher rates than national averages. Thankfully, the current rate of unintentional injury deaths to 0-14 year olds is significantly less than it was in 2007 (11.4), and just over half what it was in 2002 (14.3). This dramatic improvement is likely due to a number of factors, not the least of which is the work being carried out through the Injury Prevention Center (IPC) housed at Arkansas Children's Hospital. Under the direction of Dr. Mary Aitken, the IPC has targeted high-impact injuries such as motor vehicle crashes, all-terrain vehicles, drowning, fires/burns, and falls through educational and policy interventions. Notable legislation the group has championed and that has come to fruition includes primary enforcement of seat belt usage, graduated driver's licensing for teens, a ban on cell phone use by teens while driving, a ban on texting while driving, and restrictions on children riding in the back of pickup trucks. Such laws have undoubtedly begun to show an impact, particularly on the motor vehicle crash death rate for young people 15-24 years old (which is less than half what it was in 2007).

Another initiative likely to be showing dividends in terms of fatal injury prevention is creation of the state trauma system (see SPM03). Created by legislative action in 2009, the system is developing rapidly under the auspices of the ADH Trauma Section in the Injury Prevention and Control Branch. For children, both Arkansas Children's Hospital and LeBonheur Children's Hospital in Memphis have now been designated as Level 1 trauma centers.

Non-fatal injuries among children and youth (HSI #04) have also decreased in Arkansas as a result of ACH Injury Prevention Center activities. Additionally, the trauma system has set aside funds for primary injury prevention which are being utilized in local communities in conjunction with Hometown Health Improvement Initiative coalitions and local hospitals.

Rates of Chlamydia infection among teenage females and women of childbearing age (HSI #05) have continued to rise in recent years and therefore remain a concern. Screening of both males and females for Chlamydia began in Arkansas Department of Health Clinics in 1999. Sexually transmitted disease (STD) testing, counseling, treatment and partner referral is provided in 95 ADH Local Health Units and satellite clinics. The majority of women screened for Chlamydia in local health units are seen through the family planning program. The family planning program follows the CDC IPP (Infertility Prevention Program) guidance to focus on testing for women

under 25 years old. In CY2011, the ADH Public Health Laboratory reported a total of 65,759 Chlamydia tests were processed with an overall 11.95% positivity rate. ADH continues efforts to screen women for all STD's, but in Arkansas Chlamydia and Gonorrhea are the most prevalent STD's. In CY2011 ADH's Family Planning program screened 54% of all female family planning patients, 63% of whom were under 25 years old (unduplicated patients). All pregnant women are tested for Chlamydia at a minimum of two screenings, at the initial visit and 34-36 weeks.

Testing for Chlamydia is also provided by the HIV/STD Section in non-traditional settings such as juvenile detention facilities and county jails. For CY 2011 the ADH STD program reported a statewide total of 16,054 cases of Chlamydia with 74% (11,922) of the cases being females; 40% (4,875) of those females were in the 15-19 age range. The STD program has been reviewing the number of patients diagnosed with Chlamydia a second time within two months of their initial diagnosis. Among ADH patients with Chlamydia in 2010, fewer than 40% of sexual partners came in for treatment, leading to the potential for re-infection of the index case. ADH leadership is pursuing a change to current Arkansas state regulations that restrict the health care provider's ability to prescribe for an STD patient's partner(s) without prior evaluation. The goal is to allow expedited partner therapy (EPT) without the need for face-to-face physician evaluation. Toward that end, ADH has requested that the Arkansas State Medical Board grant a specific waiver to the Arkansas Medical Board Regulation 2(8) to allow physicians to prescribe EPT for a person with whom the physician has not established the typical physician/patient relationship. On February 2, 2012, the Arkansas Medical Board agreed to draft a waiver which will be posted for public comment. The ADH has also presented the proposal for an EPT waiver to the Arkansas State Nursing Board. The Nursing Board has indicated that they are in support of the waiver and has referred the request to their Prescriptive Authority Committee. When approved, EPT will provide a way for ADH clinicians and clinics to prevent re-infections and new infections among patients in all age groups.

Infants and children aged 0 through 24 years by age and race/ethnicity (HSI #06A and HSI #06B) shows modest increases in size with the exception of the infants 0 to 1 and children 1 through 4 categories. Infants of Hispanic ethnicity are almost 13% of all infants in Arkansas. This reflects the rising Hispanic population in Arkansas, particularly among young families who are having children. The remaining age groups shows patterns similar to what has been seen in previous years.

The pattern of distribution of births among women of all ages by race/ethnicity (HSI #07A and HSI #07B) shows distributions similar to the previous year. However the number of births by age and race have rising slightly in 2010. The pattern of Hispanic births in Arkansas in 2010 was very similar to the pattern see in 2009.

Turning to overall deaths of children and young adults by age and race/ethnicity (HSI #08), patterns remain similar to those of previous years. Infants less than one year of age continue to die at higher rates than any other age in childhood or adolescence. Remarkably, however, the number (and rate) of African American infants who died in 2010 in Arkansas was substantially less than the number who died in 2009, for reasons that remain unclear. Numbers of 15-24 year olds who died in 2010 were also reduced compared to 2009, probably due in part to reductions in motor vehicle crash deaths and development of the state trauma system. Deaths among Hispanic infants and children remained similar to the previous year.

An exciting new project spearheaded by ADH Family Health involves child and infant death review. Under contract with Arkansas Children's Hospital Research Institute, three local/regional death review teams have been established within the past year and are beginning to review cases. A total of 7 counties are covered by these new teams, which have been set up to follow National Center for Child Death Review guidelines. The legal authority for the project comes from an act passed in 2005 that designates the Arkansas Commission on Child Abuse, Rape, and Domestic Violence as lead agency in establishment of a state-level Child Death Review (CDR) panel. Although the CDR panel had been convened for several years, no actual cases had been

reviewed until ADH came forward with seed funding. Plans are to grow the project gradually as interested individuals in new counties come forward and as funding allows.

As a final consideration in this discussion, the pervasive and persistent effects of poverty must be mentioned. At the macro level, poverty underlies many poor health outcomes, and Arkansas is certainly no stranger to poverty. According to the most recent U.S. Census estimates (HSI #11), about one in six Arkansans lives below the federal poverty level, and nearly half earn less than 200% the FPL. The latter figure has actually worsened slightly in the last few years in association with the economic recession. Children continue to fare worse than the general populace in this regard (HSI #12), with almost one-fourth at less than FPL and well over half at less than 200% FPL. Reversing the effects of poverty through targeted health programs has shown some successes over time but remains extremely challenging. Eliminating poverty itself requires a much broader social strategy and the political will to get it done. In the meantime, programs that demonstrate evidence of breaking the poverty cycle, e.g. Nurse-Family Partnership, will continue to be directed to Arkansas families for whom impact will be greatest.

F. Other Program Activities

The Title V Program provides the underpinning for virtually all maternal and child health efforts conducted through the Arkansas Department of Health. Examples of MCH-related activities not covered extensively elsewhere in this document include:

Health Literacy - . In May 2010, PHLA became an office section of the Arkansas Public Health Association (APHA) which will provide PHLA with an excellent (and affordable) venue for hosting an annual meeting and providing training and continuing education in health literacy.

Training - The Center for Health Training and the ADH Women's Health Section sponsored the Women's Health Care Update 2010 on March 12th, 2010. National speakers presented information to over 200 participants on the following topics: Health Literacy, Reproductive Health Community Outreach, Reproductive Life Planning and Unplanned Pregnancy. A separate training on Client Centered Counseling was provided by Women's Health to the Northwest Region in April 2010.

Medical Supervision of Chronic Disease Programs - The Breast and Cervical Cancer Control Program (BreastCare) housed in the Chronic Disease Branch targets women over 40 who are uninsured or underinsured and who have rarely if ever been screened for breast or cervical cancer. The program offers free screening and follow-up to women who qualify. BreastCare has collaborated with a number of community organizations to provide outreach and education to vulnerable populations of women. The ADH Women's Health Physician Specialist, a board-certified OB/GYN, provides medical consultation to the program with regard to interpretation of screening results and referrals for additional testing. In addition to breast and cervical cancer, Title V staff at both the state and local level collaborate in other Chronic Disease initiatives such as diabetes prevention and control.

Community Health Promotion - Often utilizing Title V-supported ADH staff, Hometown Health Improvement Coalitions in all five regions carry out a variety of community activities that address issues including, but not limited to, teen pregnancy prevention, nutrition, physical activity and tobacco cessation. The primary target audiences are children in schools, worksites and aging Arkansans. Numerous activities throughout the state occur in various counties and include facilitation of health education presentations, dissemination of health education materials, organization of health awareness information booths, coordination of local health fairs, and implementation of special health-related and teen pregnancy prevention programs.

Enabling Services for Medicaid Beneficiaries - Also deserving of another mention is the work

performed by the Health Connections Section within the Family Health Branch. Health Connections conducts the ConnectCare program under contract with Arkansas Medicaid. The program links both new and established Medicaid recipients with available primary care providers and dentists. Health Connections also provides outreach services to Medicaid beneficiaries using various modalities. Although most of the Section's funding is from Medicaid, Title V provides some direct financial support. Leaders in the Family Health Branch also provide direct administrative support and supervision for Health Connections Section personnel.

Toll Free MCH Line - (1-800-235-0002) is maintained under the auspices of the Health Connections Branch. Health Connections maintains detailed records on calls received including date, county of origin, and subject of the call. In SFY 2009, about 16,600 calls were received. The majority (about 13,500) pertained to the Happy Birthday Baby Book. The other 3,100 calls were on a variety of subjects such as how to access the closest WIC Office and where to go for other services such as family planning and immunizations. ***/2013/ In 2010, the number of calls shrunk to 5388, due to the Baby Book campaign being temporarily suspended. //2013//***

/2013/ In September 2011, Arkansas was awarded two federal grants to help develop, expand and evaluate home visiting services in the state. The close collaboration between the Arkansas Department of Health and Arkansas Children's Hospital allowed for the development and coordination of the application for the competitive Home Visiting Grant to expand the Arkansas Home Visiting Network. The unprecedented collaboration among various home visiting providers created the unique opportunity to not only expand services to rural, small town and urban families but also to strengthen and sustain a statewide network for resource sharing. The lead agency is the Arkansas Department of Health (ADH). The coordinating partner is Arkansas Children's Hospital (ACH). The evaluation is being done by the University of Arkansas for Medical Sciences (UAMS). The training institute is conducted by UAMS Department of Pediatrics. The models being used are Home Instruction for Parents of Preschool Youngsters, Parents as Teachers, Healthy Families America, and Following Babies Back Home. We plan to add the Nurse Family Partnership in the upcoming year.

The Arkansas Home Visiting Network incorporates four key goals that will build collaboration, provide better site planning and increase quality services including training and evaluation. These goals are:
•Expand the four models engaged in year one of the grant to include 2,275 more families at 29 new sites and 26 expanded sites
•Develop the Arkansas Home Visiting Training Institute to ensure all home visitors in the state have access to relevant and topical professional development pro-grams so that families are served by highly skilled and effective home visitors
•Conduct a comprehensive evaluation of the project and family outcomes to show improvement in federal maternal and child health benchmarks
•Strengthen the Arkansas Home Visiting Network to support the state's home visiting programs in providing families with the education, support and resources

The network will help reach across economic, geographic and culture boundaries to help raise Arkansas children out of the lowest quartile in measured health and education outcomes. Network participants visit families referred from neonatal intensive care units, parents who want to become their child's first teacher and young mothers who want to increase their capacity to be excellent parents. Home visiting is an integral part of Arkansas' early childhood continuum of services focused on enhancing parenting skills that specifically target their child's needs. Once the expansion of the network is complete, home visiting programs will be active in all 75 counties in Arkansas.

The Arkansas Home Visiting Network has already reached several critical milestones in their work together:
•The National Advisory Council was established and held its first meeting on November 16th. Advisors include Anne Duggan (John Hopkins University), Deanna Gomby (Gomby Consulting),

Skip Rutherford (Dean, Clinton School of Public Service), and Karen Benjamin (Prevent Child Abuse America)
•The benchmark plan, which identifies critical outcomes and measures, has been developed
•The development of the training institute is underway with the first Home Visiting Conference scheduled for
September 26, 2012 in Hot Springs, AR
•The UAMS Division of Family Medicine and Social Solutions are working with network partners to implement
Efforts To Outcomes social services database
-The majority of the new sites have been selected and staff is recruited
•The Arkansas Home Visiting Network has established an office to co-locate with ADH staff, which will facilitate the collaborative nature of the network
•Initial planning is underway to develop a centralized intake and refererral system in three communities. //2013/

G. Technical Assistance

Health literacy is defined in Healthy People 2010 as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health information as presented in the U.S. is often unnecessarily complex. A national survey of adult literacy found that 48% of the U.S. population has inadequate or marginal literacy skills. However, health literacy entails more than just the ability to read and write -- it also encompasses skills in numeracy, listening, and speaking, and relies on cultural and conceptual knowledge. Only about 12% of adults in the U.S. have "proficient" health literacy levels. Lower health literacy leads to less healthy behaviors, poorer health outcomes, and greater health costs.

Given even lower basic literacy rates in Arkansas, there is a great need to boost health literacy among the populace as quickly as possible. Initiatives are in place to promote health literacy among older Arkansans using the Stanford Chronic Disease Self-Management Program in a train-the-trainer model. Efforts to promote the medical home concept through Medicaid and other groups may also help boost health literacy. Still, further work is needed to promote health literacy among women and children seen through local health units as well as those touched through other ADH programs. Technical assistance on how to train ADH personnel in the most effective techniques of health information transmission would therefore be desirable. Such training is consistent with the strategies found under Goal 2 (Promote Changes in the Health Care Delivery System That Improve Health Information, Communication, Informed Decision-making, and Access to Health Services) in the recently released National Action Plan to Improve Health Literacy. Technical assistance might be requested from Health Literacy Missouri or possibly national groups.

The Title V CSHCN Needs Assessment identified the need for improved communication between families and CSHCN staff related to available programs and services. The new state performance measure will be measured based on the responses to an annual program survey. Assistance is needed in developing questions that will elicit information needed to indicate our progress on the measure. The information is not available from any data source owned by the program or available to the program, nor is it measured, to our knowledge, by other survey instruments such as the National Survey of CSHCN.

/2012/ The ADH Family Health Branch is committed to incorporating the life course perspective into its program operations. As a starting point, state priorities and state performance measures selected last year for the Title V MCHBG 2010-2015 funding cycle pertain to specific life stages and address issues for which social determinants are of critical importance. These priorities include trauma to children, tobacco use among women of childbearing age, obesity among school-age children, and births to 18-19 year old women. The only possible exception is the priority related to fluoridation of water systems, which benefits all age groups but most especially

children.

From a process perspective, planning is still ongoing within the Branch regarding the best means of inculcating life course and social determinants theory into everyday practice. Further training of program and field (local health unit) staff is undoubtedly needed to ensure understanding and acceptance of the concepts. Policies related to MCH may also need to be altered to reflect incorporation of a life course perspective. Additionally, external partners of the MCH program should understand the framework so that collaborative efforts may proceed and grow.

Assistance with the development of the internal expertise to train others on life course concepts and how they can be incorporated into the planning and evaluation of the MCH activities would be beneficial.

Technical assistance for the development of a regional measure targeting the reduction of infant mortality and the identification of evidenced based and promising practices to reduce infant mortality will be helpful. The Region VI Title V Directors have been discussing the idea of having a regional performance measure. Infant mortality reduction is a common area of focus. In addition the State Health Officers in Regions IV and VI have identified infant mortality as a priority and possibly have the two regions have it as a common measure. Technical assistance to aid in bringing together the states in Region VI and to develop a regional measure targeting the reduction of infant mortality and the identification of evidenced based and promising practices to reduce infant mortality will be beneficial. //2012//

/2013/ Assistance with the development of the internal expertise to train others on the life course concepts and how they can be Incorporated into the planning and evaluation of the MCH activities. Planning is still ongoing within the Branch regarding the best means of inculcating life course and social determinants theory into everyday practice. Further training of program and field (local health unit) staff on integrating an approach to health of individuals throughout the life span is undoubtedly needed to ensure understanding and acceptance of the concepts. Policies related to MCH may also need to be altered to reflect incorporation of a life course perspective. Additionally, external partners of the MCH program should understand the framework so that collaborative efforts may proceed and grow. //2013//

/2013/ Communication is a basic requirement of the development and maintenance of partnerships. Assistance with the development of a web site to provide information and data to the state partners that work toward the improvement of maternal and child health. To facilitate the sharing of information and bring a common focus to MCH issues in our state. Technical assistance on content as well as creating a web site would be most beneficial.//2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	7097785	6659824	7004520		6937392	
2. Unobligated Balance *(Line2, Form 2)*	679554	296749	467918		401034	
3. State Funds *(Line3, Form 2)*	7658325	6240875	5900929		6414758	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	147663	35351	102232		187961	
6. Program Income *(Line6, Form 2)*	18734874	14333913	17660686		24254235	
7. Subtotal	34318201	27566712	31136285		38195380	
8. Other Federal Funds *(Line10, Form 2)*	4963156	4139738	7541366		13743270	
9. Total *(Line11, Form 2)*	39281357	31706450	38677651		51938650	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2649786	2335328	3237823		3608997	
b. Infants < 1 year old	4663610	5975195	5839714		6315505	
c. Children 1 to 22 years old	5453294	4162435	4202712		4162435	
d. Children with	5730830	4824395	5631319		5504803	

Special Healthcare Needs						
e. Others	14355889	8986278	10701103		17198273	
f. Administration	1464792	1283081	1523614		1405367	
g. SUBTOTAL	34318201	27566712	31136285		38195380	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		90235		85500	
c. CISS	245000		140000		150000	
d. Abstinence Education	0		619176		615360	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	530483		175000		543982	
j. Education	0		0		0	
k. Home Visiting	0		0		7439730	
k. Other						
DHHS-ACF-PREP	0		0		495595	
HRSA Universal Heari	0		0		233918	
Title X	3904621		4219375		4179185	
CDC Rape Prevention	0		325159		0	
DHHS-ACF-Per Resp &	0		476238		0	
HRSA	183052		300000		0	
HRSA - ACA Home Visi	0		1196183		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	20149556	16397244	19296710		23765556	
II. Enabling Services	6102013	4641609	5589743		6535166	
III. Population-Based Services	5412611	4247925	3749826		4826358	
IV. Infrastructure Building Services	2654021	2279934	2500006		3068300	
V. Federal-State Title V Block Grant Partnership Total	34318201	27566712	31136285		38195380	

A. Expenditures

Total Expenditures for the Total State MCH Budget FFY 2009 ($36,627,138) and the Federal-State MCH Partnerships ($31,709,509) was a substantial increase from FFY 2008. Expenditures at the Arkansas Department of Health and the Arkansas Department of Human Services

increased due in part to higher salaries and increased supply costs. Total expenditures were greater than those budgeted, especially in Direct Care Services. The ADH's new time allocation system has captured significantly greater effort (salaries and fringe) in the MCH programs, which was paid with State general revenue. This is a more accurate estimate than we previously were able to obtain. In addition, we have included additional funds expensed on the Newborn Screening Program that represent expansion of that program and lab costs that were not included before.

The total state match contribution of $26,540,862 more than met the Maintenance of Effort requirement of $5,797,136. The Arkansas Department of Health cost allocation system has significantly increased the amount of State contribution to the MCH Programs, because the amount of staff time spent on MCH Programs was higher than previously estimated.

Expenditures of program income of $16,950,605 were more than the $13,052,724 budgeted. Increased expenses for salary and fringe for clinic staff resulted in higher than projected costs. In addition the Expansion of our Newborn Screening Program contributed to expenses being higher than projected. This increase in cost was funded through the cost allocation system and increased fees for Newborn Screening.

Administrative costs increased as new support staff have been added. In addition the new cost allocation system recorded effort for MCH administration that had been missed previously.

/2012/ Total Expenditures for the Total State MCH Budget FFY 2010 ($33,604,701) and the Federal-State MCH Partnerships ($28,169,906) was a decrease from FFY 2009. Expenditures at the Arkansas Department of Health due in part to state general revenue used to support saleries and fringe in the Family Planning Program are not reported here, where they had been reported in last years application. It is not being reorted in this application, so that it may be used as state match for the Title X grant. The ADH's new time allocation system has captured significantly greater effort (salaries and fringe) in the MCH programs, which was paid with State general revenue. This is a more accurate estimate than we previously were able to obtain.

The total state match contribution of $23,663,847 more than met the Maintenance of Effort requirement of $5,797,136. The Arkansas Department of Health cost allocation system has significantly increased the amount of State contribution to the MCH Programs, because the amount of staff time spent on MCH Programs was higher than previously estimated.

Expenditures of program income of $15,175,694 were slightly less than the $16,037,409 budgeted. The budget for 2010 was $3,000,000 more than the prior year. This was an estimation that turned out to be too high. //2012//

/2013/ Total Expenditures for the Total State MCH Budget FFY 2011 ($31,706,450) and the Federal-State MCH Partnerships ($27,566,712) was a decrease from FFY 2010. Expenditures at the Arkansas Department of Health due in large part to the Family Planning time allocation and reduction in CSHCN case management. Family Planning time allocation is not being included in the expenditures, so that it may be used for match for the Title X grant. Previously this was split between grants.
The total state match contribution of $20,610,139 more than met the Maintenance of Effort requirement of $5,797,136. Expenditures of program income of $14,333,913 were less than the $18,734,874 budgeted, due to the cost of contraceptives leveling off. The budget for 2011 was over $6,000,000 more than the prior year. This was an estimation that turned out to be too high. //2013//

/2013/ The state funds spent in CSHCN total $1,768,822. The remainder of the required state match in CSHCN is derived from expenditures on direct services and insurance collections. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. CSHCN expenditures of

program income for FFY 2011 was $1,091,297, slightly more than what was budgeted. //2013//

B. Budget

Preventive and Primary Care for Children is budgeted at $4,258,671 or 60 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is $2,224,446, which is 31.34 percent of the total. The Title V administrative costs are estimated at $614,668, or 8.66 percent of the total allocation. The amount of total State funds budgeted is $7,658,325, which is a significant increase from the amount budgeted previously. This reflects state dollars directly budgeted in the Arkansas Department of Health (ADH) and the Arkansas Department of Human Services' MCH programs and to the state effort through salaries paid from state general revenue that support MCH programs captured in time allocation reports. Time allocation is more accurate than it had been in the previous application due to a new time allocation system at ADH. The total state match is $26,540,862. Each of these budgeted items satisfies the legislative requirements.

The state funds spent in CSHCN total $1,927,852. The remainder of the required state match in CSHCN is derived from expenditures on direct services and insurance collections. Without these insurance collections, CSHCN would have to pay more out of state funds to the hospital for direct medical services. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. CSHCN program income for FFY 2009 fell below projections due to reduced reimbursements.

Policy Development, Program Development and Management are included in the administration of Title V. Quality Assurance and Standards Development and Community Assessment are included in the program partners making up the Title V Block Grant. The Title V Block Grand funds provide an essential link between the programs in our state serving children and mothers. The funds provide a bridge between the Arkansas Department of Health and the Arkansas Department of Human Services, that creates a partnership resulting in better coordination and efficiency in serving the citizens of the state. It also serves as a platform from which new initiatives and partnerships outside of state government, such as the Natural Wonders Partnership, are made to tackle the health issues of the State's children and women.

/2012/ Preventive and Primary Care for Children is budgeted at $4,202,712 or 60 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is $2,195,217, which is 31.34 percent of the total. The Title V administrative costs are estimated at $606,591, or 8.66 percent of the total allocation. The amount of total State funds budgeted is $5,900,929, which is a decrease from the amount budgeted previously. This reflects state dollars directly budgeted in the Arkansas Department of Health (ADH) and the Arkansas Department of Human Services' MCH programs and to the state effort through salaries paid from state general revenue that support MCH programs captured in time allocation reports. Time allocation for ADH is less this year because the salaries and fringe paid for by the state for the Family Planning Program is being counted in the match for the Title X Grant. Last year those dollars had been counted as match for the Title V grant application. This is why the State funds expensed for 2010 are less and the state funds budgeted for 2012 are less than before. The total state match is $23,663,847. Each of these budgeted items satisfies the legislative requirements.

The state funds spent in CSHCN total $1,688,336. The remainder of the required state match in CSHCN is derived from expenditures on direct services and insurance collections. Without these insurance collections, CSHCN would have to pay more out of state funds to the hospital for direct medical services. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. CSHCN program income for FFY 2010 was $1,338,255 and they expensed $1,147,531, slightly less than what was budgeted.

Policy Development, Program Development and Management are included in the administration

of Title V. The Title V Block Grand funds provide an essential link between the programs in our state serving children and mothers. The funds provide a bridge between the Arkansas Department of Health and the Arkansas Department of Human Services, that creates a partnership resulting in better coordination and efficiency in serving the citizens of the state. It also serves as a platform from which new initiatives and partnerships outside of state government, such as the Natural Wonders Partnership or the Arkansas Home Visiting Network, are made to tackle the health issues of the State's children and women. //2012//

/2013/ Preventive and Primary Care for Children is budgeted at $4,162,435 or 60 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is $2,174,179, which is 31.34 percent of the total. The Title V administrative costs are estimated at $600,778, or 8.66 percent of the total allocation. The amount of total State funds budgeted is $6,414,758, which is a slight increase from the amount budgeted previously. This reflects state dollars directly budgeted in the Arkansas Department of Health (ADH) and the Arkansas Department of Human Services' MCH programs and to the state effort through salaries paid from state general revenue that support MCH programs captured in time allocation reports. The total state match is $30,856,954. Each of these budgeted items satisfies the legislative requirements.

Budget for CSHCN for FFY12 shows a slight decrease bring it closer to FFY11 expenditures.
Policy Development, Program Development and Management are included in the administration of Title V. The Title V Block Grant funds provide an essential link between the programs in our state serving children and mothers. The funds provide a bridge between the Arkansas Department of Health and the Arkansas Department of Human Services, that creates a partnership resulting in better coordination and efficiency in serving the citizens of the state. It also serves as a platform from which new initiatives and partnerships outside of state government, such as the Natural Wonders Partnership or the Arkansas Home Visiting Network, are made to tackle the health issues of the State's children and women. //2013//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.